The LEWIN GROUP

Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings

A Review of the Literature

Prepared for:

The Health Resources and Services Administration

September 2001

Prepared by:
The Lewin Group, Inc.

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Introduction

I. INTRODUCTION

A. Project background and objectives

The Health Resources and Services Administration (HRSA) is sponsoring a project to develop a cultural competence measurement profile comprising a conceptual measurement framework and set of measures for gauging cultural competence in health care settings. HRSA has contracted The Lewin Group to conduct this work. The goal of this effort is to contribute to an understanding of how the complex construct of cultural competence can be measured and advance the capacity of organizations to carry out such measurement.

As the Nation's "Access agency," HRSA recognizes that cultural competence is an essential component of accessible, responsive, and high quality health services. Ensuring cultural competence is a key strategy in HRSA's commitment to achieving a goal of providing access to quality health care for all. HRSA also recognizes that a key mechanism for ensuring cultural competence is the ability to measure it for purposes related to developing, monitoring, and evaluating health care services. While the field has made strides in this area, much more needs to be known. Through this project, HRSA hopes to make a contribution to the field by providing a measurement profile that can serve as a building block for future work by HRSA and others interested in culturally competent health service delivery, including consumers, providers, policy makers, and researchers.

The objectives of this project are to: 1) develop a conceptual framework for measuring cultural competence in health care settings; 2) identify specific indicators and measures that can be used to assess cultural competence within health care; and 3) assess the feasibility and practical application of these measures. The following report details a comprehensive review of the cultural competence theoretical and methodological literature. This report is one component of the larger measurement profile project, which involves further development and refinement of the profile through site visits to best practice health care organizations and clinics, as well as discussions with experts in the field.

This literature assessment serves two related purposes. The first is to synthesize and examine the state-of-the-art of measurement of cultural competence, particularly as related to health care, in order to develop a potentially useful resource for the field. In addition, the literature assessment will provide a basis for decisions about the scope, content, and value of the measurement profile to be developed in this project.

B. Organization of the Report

This report begins with a review of how cultural competence has been conceptualized. The identification and discussion of the areas in which cultural competence must be evidenced are presented as critical domains for measuring cultural competence. The report then presents and applies a measurement framework for the identification and

Section II: Conceptualizing Cultural Competence and Identifying Critical Domains

II. CONCEPTUALIZING CULTURAL COMPETENCE AND IDENTIFYING CRITICAL DOMAINS

Based on the literature review, this section reports on the current state of the field in conceptualizing cultural competence and identifies key domains or areas for measuring cultural competence. This section also provides a synthesis of the literature that provides a basis for each of the domains identified by the project team. A full annotation of the articles reviewed for this analysis can be found in the bibliography at the end of this document.

A. Approaches to conceptualizing cultural competence

Many health care professionals agree that cultural competence is a critical factor in providing relevant services to the nation's growing culturally and ethnically diverse patient population. An extensive body of literature exists that describes the evolution of cultural competence in the context of health care. The following discussion primarily focuses on this body of work, recognizing that literature outside of the health care sphere (e.g., social marketing, anthropology, communication and media, etc.) could also enhance the understanding of cultural competence in health care. While many articles addressing the concept of cultural competence were reviewed, the project team identified five central works. The authors of these five works are Cross, T.L., Bazron, B.J., and Isaacs, M.R, Campinha-Bacote, J., Carballeira, N., Leininger, M., Davidhizar, R., and Giger, J.N. These works were chosen as seminal literature because of their scope and substance, their frequent citation in the literature, and the consensus validation of their ideas and perspectives in works of many other authors.

The literature provides health care professionals with several definitions of cultural competence and numerous methods for providing culturally competent care. For the purpose of this review, we use the definition of cultural competence set forth by Cross, T.L., Bazron, B.J., Dennis, K.W., Isaac, M.R., and Campinha-Bacote, J. [1,2] Cultural competence is *"a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations."*[1]

The literature on cultural competence approaches the issue of competence in two ways: theoretical and methodological. For example, Cross, et al. and Campinha-Bacote offer a theoretical approach in which cultural competence is seen as a process or continuum whereby an individual's view of other cultures transforms from destructive or unaware to

[1] Cross TL, Bazron BJ, Dennis KW, Isaacs MR (1999). **Toward a Culturally Competent System of Care, Volume 1.** National Institute of Mental Health, Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Georgetown University Child Development Center.

[2] Campinha-Bacote J, Yahle T, Langenkamp M (1996). The challenge of cultural diversity for nurse educators. **Journal of Continuing Education in Nursing**, 27(2), 59-64.

proficient.[1,3] Cross, et al. define a set of factors that must be present in order to progress along the continuum. There are six possible points along this continuum:

1. Cultural destructiveness,
2. Cultural incapacity,
3. Cultural blindness,
4. Cultural pre-competence,
5. Cultural competence, and
6. Cultural proficiency.

Furthermore, Cross, et al. describe several conditions that must exist in order for professionals to move along this continuum. Professionals must: value diversity, understand their cultural biases, be conscious of the dynamics that occur when cultures interact, internalize cultural knowledge, and develop adaptations to diversity. Each of these conditions set by Cross, et al. must function at every level of the health care system in order for that system to provide culturally competent care.

Similar to Cross, et al., Campinha-Bacote views cultural competence as a process, not an endpoint, in which health professionals continually strive to work within the cultural context of the patient.[3] The process requires health care providers "to see themselves as becoming culturally competent rather than being culturally competent."[1] Although Campinha-Bacote does not define points in this process of becoming, the author does outline five components of cultural competence similar to the five essential elements presented by Cross, et al. The five components of competence include:

1. Cultural awareness,
2. Cultural knowledge,
3. Cultural skill,
4. Cultural encounters, and
5. Cultural desire.

Health care providers can work on any one of these constructs to improve the balance of all five, but eventually all five constructs must be experienced and addressed. Campinha-Bacote explains that the intersection of these constructs represents the process of cultural competence, and as the area of intersection becomes bigger, health care providers will internalize cultural competence at a deeper level and provide higher quality care.

Authors such as Carballeira, Leininger, and Davidhizar and Giger offer a more methodologically driven approach that focuses on the methods a professional might use in order to become culturally competent and provide culturally competent care.[4,5,6] These

[3] Campinha-Bacote J (1999). A model and instrument for addressing cultural competence in health care. **Journal of Nursing Education**, 38(5), 203-207.

[4] Leininger M (1993 Winter). Towards conceptualization of transcultural health care systems: concepts and a model (classic article from 1976). **Journal of Transcultural Nursing**, 4(2) 32-40.

[5] Leininger, M as cited in Cooper, T (1996). Culturally appropriate care: optional or imperative. **Adv Proc Nursing Quarterly**, 2(2), 1-6.

authors typically assume that cultural competence is a goal that can be reached when a skill set is learned with the proper training.

Specifically Carballeira depicts the interaction between a provider and a client as a cross-cultural exchange of attitudes.[7] The author suggests that in a health care setting, the patient simply reacts to the provider's "cultural attitude." Similar to the Cross, et al. and Campinha-Bacote continuum models, Carballeira proposes that the provider's cultural attitude falls within a range: superiority, incapacity, universality, and sensitivity, to competence. Additionally, Carballeira explores the patient's reaction to the provider where the client's reaction ranges from resistance to accommodation to adaptation. The author suggests the use of the LIVE & LEARN model which presents providers with a practical, phased approach to cross cultural service delivery that respects client centrality, avoids stereotyping, and leads to the adoption of mutually acceptable objectives and measures for changed behavior. In this model, the acronym "LIVE" stands for **L**ike, **I**nquire, **V**isit, and **E**xperience, while "LEARN" stands for **L**isten, **E**valuate, **A**cknowledge, **R**ecommend, and **N**egotiate.

Leininger's Sunrise Model provides a method for assessing patients in order to provide comprehensive and culturally sensitive care.[4] Leininger believes that the Western medical model fails to explore cultural patterns of illness. The Sunrise Model suggests that the world view and social structure of the client are important areas to investigate and can be explored using seven dimensions:

Approaches to Conceptualizing Cultural Competence

A large body of knowledge exists regarding ways to think about cultural competence. The following authors are highlighted because of their scope and substance, their frequent citation in the literature, and the consensus validation of their ideas and perspectives in the works of many other authors:

Cross, Bazron, and Isaacs discuss how the process of cultural competence progresses along a continuum that ranges from cultural destructiveness to proficiency.

Campinha-Bacote outlines five components of cultural competence: awareness, knowledge, skill, encounters, and desire.

Carballeira introduces the "LIVE & LEARN" model where "LIVE" stands for Like, Inquire, Visit, and Experience, while "LEARN" stands for Listen, Evaluate, Acknowledge, Recommend, and Negotiate.

Leininger describes a Sunrise Model that includes seven dimensions:
1. Cultural values and lifeways,
2. Religious, philosophical, and spiritual beliefs;
3. Economic factors,
4. Educational factors,
5. Technological factors,
6. Kinship and social ties, and
7. Political and legal factors.

Davidhizar and Giger present a model of transcultural assessment that examines:
1. Communication,
2. Space,
3. Time,
4. Social organization,
5. Environmental control, and
6. Biological variations.

[6] Davidhizar R, Bechtel G, Giger, JN (1998). A model to enhance culturally competent care. **Hospital Topics: Research and Perspectives on Healthcare**, 76(2), 22-26.

[7] Carballeira N (1997 January-February). The LIVE and LEARN model for cultural competent family services. **Continuum,** 7-12.

1. Cultural values and lifeways,
2. Religious, philosophical, and spiritual beliefs,
3. Economic factors,
4. Educational factors,
5. Technological factors,
6. Kinship and social ties, and
7. Political and legal factors.

Health care professionals must develop the skills, knowledge, and patience to explore and validate what the patient says and does. Once information is obtained for each of the dimensions, health care professionals can guide patient treatment and interventions. According to this Sunrise Model, providers should base their selection of a treatment approach or combination of approaches on information gathered from the assessment. Leininger suggests that this guidance can occur in a variety of ways: cultural care preservation and/or maintenance, cultural care accommodation and/or negotiation, and cultural care repatterning and/or restructuring.

Davidhizar and Giger also present a transcultural assessment model to assist health care professionals in assessing patients from diverse cultures that focuses on six factors: [6]

1. Communication,
2. Space,
3. Time,
4. Social organization,
5. Environmental control, and
6. Biological variations.

According to Davidhizar and Giger, health care professionals should receive training on how to use these factors to assess the health beliefs and practices that may have a significant impact on how an individual responds to treatment and patient education. Using this assessment model will assist health care professionals in providing care that is sensitive and tailored to the needs of culturally diverse individuals.

The various approaches to conceptualizing cultural competence identified in the literature stress the importance of viewing cultural competence as a dynamic process involving continual progression and involvement of all levels of the health care system. The literature identifies essential elements and conditions that must be present in the health care system in order to support cultural competence. These essential elements will provide a basis for identifying domains for measuring cultural competence, as discussed in the Section II. B of this report.

B. Critical domains for measuring cultural competence

The conceptual literature discussed in the previous section and other literature reviewed later in this document suggest that cultural competence in health care settings must be evidenced or manifested in a broad range of spheres or areas. The project team has preliminarily identified nine such areas that are potentially important to the development of a measurement profile for cultural competence in health care settings. These areas are referred to here as domains, and include:

1. Values and attitudes,
2. Cultural sensitivity,
3. Communication,
4. Policies and procedures,
5. Training and staff development,
6. Facility characteristics, capacity, and infrastructure,
7. Intervention and treatment model features,
8. Family and community participation, and
9. Monitoring, evaluation and research.

Within these global domains, many specific subjects or topic areas were identified as characterizing the domain and forming the particular focus or substantive content for which indicators and measures might be identified and developed. These topic areas are discussed in Section II. C of this report. In this section of the report, the nine domains are defined with regard to providers'/health care organizations' cultural competence and discussed with respect to the domains' linkage to the key conceptual literature.

Critical Domains for Measuring Cultural Competence

Analysis of the conceptual and other literature led to the extrapolation of nine "domains" that provide a basis for developing a measurement profile.

Values and attitudes refer to beliefs held by healthcare professionals, organizations that influence health care delivery.

Cultural sensitivity denotes the providers' heightened awareness and can be a precursor to changing values, attitudes, and behaviors.

Communication encompasses the variety of ways that describe how the exchange of information among those involved in care delivery occurs.

Policies and procedures consist of the programmatic and planning vehicles through which organizations can facilitate the provision of culturally competent care.

Training and staff development concentrate on providing professionals with the requisite knowledge and skills to supply culturally competent care.

Facility characteristics, capacity, and infrastructure focus on access and availability of care and the environment in which it is provided, including location, physical resources, and information systems.

Intervention and treatment model features includes evaluation, diagnosis, treatment, and referral and how culture-specific knowledge and sensitivity can enhance them.

Family and community participation recognizes the role of the family and community in achieving quality health care.

Monitoring, evaluation and research includes activities to assess progress in cultural competence efforts as well as to create and disseminate new knowledge.

Areas of overlap exist where topic areas align with several domains. These areas of overlap are highlighted in Section II.C.

Domain 1: Values and attitudes

Values and attitudes refer to the set of beliefs and mindsets possessed by providers, administrative staff, health care organizations and others involved in service delivery. The discussion of values and attitudes in the conceptual literature is intertwined with discussions of cultural sensitivity (see below). The conceptual literature emphasizes training, assessment, and cultural encounters in order for providers to increase the awareness of the values and attitudes they bring to the consumer-provider interaction. Cultural encounters also increase providers' ability to understand those that consumers bring with regard to health, medical treatment, and authority. In other words, provider values and attitudes toward other cultures can change through cross-cultural interactions with clients and by developing knowledge about and adaptation to this diversity. Leininger's theory requires health care professionals to evaluate, acknowledge, and develop respect for the cultural differences. This can be accomplished through active listening, open-ended questions, and a nonjudgmental attitude toward the differences that are encountered. Carballeira stresses the importance of the provider's "cultural attitude" and describes a range of attitudes, from "superiority" to "competence." At the "competence" level, the provider can respect client centrality, avoid stereotyping, and adopt mutually acceptable objectives and measures for changed behavior.

Domain 2: Cultural sensitivity

Cultural sensitivity generally refers to heightened awareness and complements several other domains, most notably communication. While values and attitudes refer to the beliefs held by health care professionals, cultural sensitivity refers to heightened knowledge of the needs of the client. Often, cultural sensitivity manifests itself in a provider's ability to accurately interpret and respond to non-verbal or other cultural cues or in the way in which health care organizations provide information to their clients. This sensitivity can lead to the behavioral adaptations needed for cultural competence. For example, Cross, et al. and Campinha-Bacote both view cultural competence as a continuum. As a person moves along the continuum, their values and attitudes undergo a transformation from a state of ignorance to one of competence. However it is also possible for an individual to be culturally aware, and not change behaviors to become culturally competent.

Domain 3: Communication

Communication encompasses a wide range of activities, both oral and written, that describe the flow and exchange of information among those involved in the provision and receipt of care, including interpersonal exchanges and exchanges between individuals and organizations. Cultural factors affect the consumer-provider communication. Cultural competence leads to actions creating concordance in communication styles and increasing the availability and accessibility of language services (e.g., interpretation and translation) to improve communication. Improved communication can lead to increased consumer satisfaction as well as an improved understanding of and compliance with diagnoses and treatment regimens. From a conceptual perspective, Davidhizar and Giger focus heavily on communication as a key tool for improving cultural competence in their theory of transcultural assessment. Providers must assess the patient's communication

style to learn about cultural-specific cues that are used. For example, an understanding of these communication cues can assist the provider in explaining procedures and instructions.

Domain 4: Policies and procedures

Policies and procedures refer to the programmatic and planning vehicles through which organizations can facilitate the provision of culturally competent care. Specifically, this includes mechanisms, such as conflict resolution processes and hiring procedures, as well as other devices that operate primarily in managed care settings, such as the breadth of provider networks and types of incentive systems. Cross, et al. discuss policies and procedures in the context of their continuum of care. As an agency or professional moves toward cultural competence, they begin to understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele. Those that are culturally blind (a mid-point along the continuum) may believe that they are implementing culturally competent policies when, in fact, their policies may be discriminatory and ultimately restrict access to services. When an agency or professional reaches cultural proficiency, policies are flexible and culturally impartial.

Domain 5: Training and staff development

Training and staff development concentrates on how to provide health care professionals the knowledge and skills required to supply culturally competent care. An understanding of providers' individual skill and knowledge level represents a starting point from which to develop programs and curricula to develop cultural competence among health care providers and other staff in health care settings. Conceptually, the literature often presents training and professional development in the context of interventions and treatment. However, the domain also addresses the training that happens in academic institutions. Campinha-Bacote, Carballeira, Leininger and Davidhizar and Giger agree that health professionals should be trained to collect relevant cultural data when conducting health histories and assessments. Although training and staff development potentially constitutes a topic area within policies and procedures, numerous training efforts profiled in the literature as well as the conceptual emphasis on its importance led to its categorization as a separate domain.

Domain 6: Facility characteristics, capacity, and infrastructure

Facility characteristics, capacity, and infrastructure refer to issues related to the access and availability of care and the environment in which it is provided, including location, hours of operation, physical resources, and information systems. Often, these issues influence consumers' experiences in a health care delivery setting and can hamper their capacity to access it. Cross, et al. address this issue when discussing the influence of an organization's infrastructure on its ability to be culturally competent. An organization in seeking to become culturally competent can address the needs of different cultures by developing service models that are adapted to the cultural-specific needs of the population.

Domain 7: Intervention and treatment model features

Interventions and treatment model features focus on aspects of patient evaluation, diagnosis, treatment, and referral services. These can include how traditional healing beliefs interrelate with the Western medical model, ethnopharmacology, inclusive decision-making, care coordination, and, in a managed care context, health benefit design. Conceptually, Campinha-Bacote, Carballeira, Leininger and Davidhizar and Giger discuss how culturally competent evaluation of consumers can assist providers in planning interventions and treatments. Basing diagnoses on a cultural assessment that is sensitive to the cultural needs and beliefs of the patient and sharing it with consumers in a culturally sensitive manner can contribute to consumers' increased understanding of diagnoses and treatment. This increased understanding is a step towards improving compliance with a treatment regimen and addressing consumers' health concerns. To truly address issues of intervention and treatment providers must understand the epidemiological profile of the client base.

Domain 8: Family and community participation

Family and community participation refers to family centered, family focused, and family-oriented care that recognizes the important role of the family and the larger community in the provision of health care. Community participation in assessments and community outreach efforts represent means for providers to develop an understanding of consumers' cultural backgrounds and support structures and to include these perspectives into policy planning and development and other activities. The extent to which the health care system considers and incorporates input from a broader unit than the direct client influences the degree to which consumers and providers engage in culturally competent discourse. Both Leininger and Davidhizar and Giger stress that a cultural assessment of a patient should explore the social organization or kinship and social ties of the patient. This includes involving the family and/or community members when appropriate.

Domain 9: Monitoring, evaluation and research

Efforts to become culturally competent include monitoring and evaluating current efforts in order to assess the extent to which cultural competence is present, is maintained, and contributes to desired results with respect to health and health care. The spectrum of efforts includes assessing organizations, services, and consumer needs and satisfaction. In addition to evaluation and monitoring, organizations and individuals can pursue research activities designed to create and disseminate new knowledge on cultural competence. From a conceptual perspective, Campinha-Bacote suggests that providers should research and obtain a sound educational foundation about the various world views of different cultures. Developing a knowledge base helps build cultural awareness which can result in cultural competence.

Exhibit I provides a summary of the ideas related to the domains as found in the key conceptual literature and demonstrates the degree of congruence within the field. It also portrays to some extent the degree of overlap among the nine domains. As noted earlier, these nine domains represent the broad spheres or areas in which cultural competence should be evidenced or manifested in culturally competent health care settings. Within

these domains, specific topics or subjects further characterize the domains and provide clues to what might be included in a measurement profile. In Section II. C of the report and in **Attachment 3**, the domains and topic areas are discussed in light of a review of an extensive and wide-ranging set of documents and publications. (See Annotated Bibliography.)

Exhibit I
Comparison of Key Literature (Authors) by the Critical Domains of Cultural Competence

Author	Domains Identified by Lewin								
	Values and Attitudes	**Cultural Sensitivity**	**Communication**	**Policies and Procedures**	**Training and Staff Development**	**Intervention and Treatment Model Features**	**Facility Characteristics, Capacity and Infrastructure**	**Family and Community Participation**	**Monitoring, Evaluation and Research**
Cross	Cross, et al. View cultural competence as a continuum whereby professional's views of and attitudes toward other cultures change from being destructive to proficient. Health care professionals move along this continuum by building a base of cultural knowledge and developing adaptations to diversity.			Agencies or professionals that are culturally blind may believe that they are implementing culturally competent policies and procedures when in actuality their policies may be discriminatory and restrict access to services.		As health care professionals move along the continuum toward cultural proficiency, the care they provide becomes sensitive to cultural differences and the quality of care improves.	Culturally competent agencies or professionals seek to provide services that are accessible to many different cultures. They have a variety of service model adaptations in order to better meet the needs of minority populations.		
Campinha-Bacote	Cultural competence is a process whereby providers gradually build cultural awareness, knowledge and skills which result in changing attitudes toward different cultures and, eventually, cultural competence. Providers can progress toward cultural competence by having encounters with other cultures and drawing on knowledge and skills to adapt to the situation.				Professionals should be trained to collect relevant cultural data when conducting health histories and physical assessments.	Once all five factors are internalized, providers can experience cultural competence and are able to provide quality care.			It is important to obtain a sound educational foundation concerning the various world views of different cultures. This involves research and training.

Exhibit I
Comparison of Key Literature (Authors) by the Critical Domains of Cultural Competence

Author	Domains Identified by Lewin								
	Values and Attitudes	**Cultural Sensitivity**	**Communication**	**Policies and Procedures**	**Training and Staff Development**	**Intervention and Treatment Model Features**	**Facility Characteristics, Capacity and Infrastructure**	**Family and Community Participation**	**Monitoring, Evaluation and Research**
Carballeira	Carballeira's theory explores the importance of the provider's attitude toward different cultures and how culturally competent attitudes can improve the quality of patient care. As providers develop attitudes that are more sensitive to different beliefs and understandings of health and illness, they gain the ability to better assess the patient and provide more appropriate care.				Providers should be trained to use the LIVE and LEARN patient assessment models in order to avoid stereotyping, and provide competent care that leads to changed patient behavior. This patient assessment model helps providers to provide quality care because treatment is planned in a culturally sensitive way based on a cultural assessment such that patients understand treatment and change their behavior to adhere to the treatment.			
Davidhizar and Giger		Culturally sensitive encounters include an assessment that helps providers to develop awareness and knowledge of the needs of the particular patient. Included is an assessment of the patient's communication style and the verbal and nonverbal cues used by different cultures. An understanding of these communication cues assists a provider in adequately explaining procedures and instructions.			Health care professionals should be trained in the transcultural assessment model in order to assess the health and well-being of patients from different cultures. Information collected from this assessment helps to inform the treatment that is given and ultimately improves the quality of care.			The authors stress the importance of understanding the social organization of different cultures. Health care providers should be sensitive to the family's role in patient care and encourage participation if appropriate.	

Exhibit I
Comparison of Key Literature (Authors) by the Critical Domains of Cultural Competence

Author	Domains Identified by Lewin								
	Values and Attitudes	**Cultural Sensitivity**	**Communication**	**Policies and Procedures**	**Training and Staff Development**	**Intervention and Treatment Model Features**	**Facility Characteristics, Capacity and Infrastructure**	**Family and Community Participation**	**Monitoring, Evaluation and Research**
Leininger	Leininger's assessment requires health care professionals to evaluate acknowledge, and respect cultural differences in world view and social structure.				Leininger suggests that staff be trained in the use of an assessment model to explore the world view and social structure of patients from different cultures. Health care professionals must develop the skills, knowledge and patience to complete the assessment so that the results can be used to guide patient treatment and interventions. Leininger sets up a formal framework for how results can be used to inform treatment based on three modalities.		The patients' response to the facility should be noted and the patient should be made comfortable within the space whenever possible.	The assessment should explore the kinship and social ties of the patients and involve family and/or religious leaders when appropriate.	

C. Topic areas addressed by the critical domains of cultural competence

Having examined the domains and their grounding in the conceptual literature, this section presents a synthesis of the remaining literature-based evidence supporting each domain. It highlights specific behaviors, activities, and issues that address the question of cultural competence.

Domain 1: Values and attitudes

The beliefs and mindsets of organizations, professionals, and consumers influence direct care encounters, shaping the interaction between the consumer and the provider, the provider's delivery of care, and the way in which consumers perceive care.

These values can manifest themselves at different levels. At the individual level, the literature discusses the importance of acknowledging and respecting other cultures and the role of culture in health care. One particular topic area of emphasis is that of provider diversity. Beyond the individual consumer and provider, the literature highlights the importance of incorporating principles related to cultural competence in organizational missions, visions, and goals. This represents an area of overlap with the domain of policies and procedures.

Awareness and acceptance of culture and its impact on how care is delivered and received is an essential element in a culturally competent

Sample Topic Areas Addressed by the Critical Domains of Cultural Competence

Each of the domains identified contains numerous topic areas that provide a more detailed understanding of the areas in which change can be seen and therefore measured. Some specific topic areas are identified below. (See **Attachment 2** for more details)

Values and attitudes – acknowledges/ respects different cultures, diversity, mission

Cultural sensitivity –clinical and non-clinical encounters, non-verbal communication, visual representation

Communication – communication styles, interpreter, translated materials, linguistically competent organization, linguistic capacity of the provider, language ability of consumer, provide information, cultural brokering

Policies and procedures – choice of health plan network and providers, grievance and conflict resolution, planning and governance, adequate financing, staff hiring/recruitment, incentive systems, policy development

Training and staff development – new staff orientation, structured opportunities for ongoing learning, bilingual training, assessment of the knowledge and skills/attitudes of the provider, cultural knowledge, knowledge of community needs, provider preparation

Facility characteristics, capacity, and infrastructure - accessible services, physical environment, information system

Intervention and treatment model features - diagnosis, care planning, referral, and treatment, quality of care, health benefit design, input into treatment decisions, ethnopharmacology, traditional healers, interdisciplinary teams

Family and community participation - family-centered care, community and consumer participation, community outreach

Monitoring, evaluation and research – consumer satisfaction, community needs assessment, organizational assessment, evaluation of health plans and providers

program[8,9,10,11,12,13,14,15,16] and applies to both consumers and providers.[17] Cultural perceptions influence when a symptom is defined as a health problem and the severity of the problem and whether to seek advice.[18]

- Behui, et al. argue that consumers' unique sets of beliefs about the causation of their change in function and emotional experience influences their determination of who they perceive to be appropriate healers.[19]
- Perez-Stable, et al. discuss how the cultural concept of *fatalismo* (fatalism) in Latino culture may lead some Latinos to be less likely to change behavior to reduce risk or seek care.[20]

Providers who are aware of cultural beliefs also have more effective communication with consumers,[14] highlighting the interconnectedness of the domains of cultural competence.

- Oomen and Owen examine how to identify and treat Type II diabetes among Latinas and recommend that understanding consumers' perceptions of diabetes and its

[8] Munoz RH, Sanchez AM. Developing culturally competent systems of care for state mental health services. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[9] Puebla-Fortier J, Shaw-Taylor Y (1999 May). **Cultural and Linguistic Competence Standards and Research Agenda Project, Parts One and Two.** Resources for Cross Cultural Health Care, the Center for the Advancement of Health, and the Office of Minority Health, DHHS.

[10] Working Groups on Cultural Competence in Managed Mental Health Care (1997 October). **Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic groups, Final Report.** Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[11] Western Interstate Commission for Higher Education (WICHE) Mental Health Program (December 1997). **Managed care and Cultural Competency in the Delivery of Mental Health Services.** Center for Mental Health Services, Substance Abuse and Mental Health Services. December, 1997.

[12] Campinha-Bacote J. **The Process of Cultural Competence in Health Care: A Culturally Competent Model of Care.**

[13] Cross T et al (1999). "Family-based or culturally competent systems of health care," from **Towards a Cultural Competent System of Care.**

[14] Patcher LM (1994). Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. **JAMA,** 271(9), 690-694.

[15] Salimbene S (1999). Cultural competence: a priority for performance improvement action. **Journal of Nursing Care Quality**, 13(3), 23-35.

[16] Lister P (1999). A taxonomy for developing cultural competence. **Nurse Education Today,** 19(4), 313-318.

[17] Various (1998 Winter). Special section on multicultural issues: melting pot to multicultural society. **Psychiatric Rehabilitation Journal.**

[18] Klein A, Marie Martinez R, Lacerino-Paquet N (1998 January). **Background Paper for a National Assessment of Linguistically and Culturally Appropriate Services in Managed care Organizations Serving Racially and Ethnically Diverse Communities.** Mathematica Policy Research, Inc. for Department of Health and Human Services.

[19] Behui K, Bhugra D (1997 May21-June 3). Cross-cultural competencies in the psychiatric assessment. **British Journal of Hospital Medicine,** 57(10), 492-496.

[20] Perez-Stable E, Sabogal F, Otero-Sabogal R, Hiatt R, Mcphe S (1992). "Misconceptions about cancer among Latinos and Anglos." **JAMA**, 168, 3129-3223.

treatment would lead to a more culturally sensitive method of diagnoses and treatment.[21]

- Crandall, et al. discuss the importance of socially responsible values in the provider workforce by examining attitudes of medical students and how they change.[22]

Awareness and acceptance can take various forms, from acknowledgment to respect. Identification and recognition of the differences between cultures and how they shape interactions represents a first step towards accommodating and adapting care to respect those differences.[23] Carballeira posits that shifts in cultural attitudes of providers and consumers can lead to improved results, and includes elements of that shift in the "LIVE & LEARN" model. In this model, changes in consumers' reactions would shift from resistance-accommodation-adaptation while changes in providers' reactions would progress along a continuum of superiority-incapacity-universality-sensitivity-competence.[7] Ultimately, conveying respect during encounters where differences of values exist remains challenging because manifestations of respect depend on culturally-specific norms of interaction.[24] Furthermore, the impact of cultural value differences is not limited to race and ethnicity alone but extends to socioeconomic status and power dynamics that differ by race and ethnicity.[25]

In addition to awareness, acknowledgment, respect, and acceptance of cultural values and differences, several articles discuss the need to emphasize the value of diversity and other values that promote healthy outcomes for underrepresented groups.[17,25] Instilling a positive view of diversity differs from, but can co-exist with, targeted recruitment and retention efforts by health care organizations discussed under the policies and procedure domain. Promoting diversity as a value becomes important as these efforts require time and resources to progress.

At an organizational level, the literature stresses the importance of creating mission and vision statements that articulate an organization's principles and rationale related to providing culturally competent health care services. These goals and objectives can also manifest themselves in program announcements, policies, and requests for proposals.[26,27]

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[21] Oomen JS, Owen LJ (1999). Culture counts: why current treatment models fail hispanic women with type II diabetes. **Diabetes Education**, 25(2), 220-225.

[22] Crandall S, Volk R, Loemker V (1993). Medical students' attitudes toward providing care for the underserved – are we training socially responsible physicians? **JAMA**, 19, 2519-2523.

[23] Massachusetts Chronic Disease Improvement Network (1999 December). **Progress Notes: A Newsletter of the Massachusetts Chronic Disease Improvement Network.** 3(3).

[24] Browne AJ (1997). A Concept Analysis of Respect by Applying the Hybrid Model in Cross-Cultural Settings. **Western Journal of Nursing Research,** 19(6), 762-780.

[25] Texas Department of Health. **Journey Towards Cultural Competency: Lessons Learned.** National Maternal and Child Health Resource Center on Cultural Competency.

[26] Cultural Competency Subcommittee for the Hispanic Agenda for Action, Department of Health and Human Services. **Recommendations on Cultural Competency.**

[27] National Center for Cultural Competence (2000 Winter). **Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy-Makers. Policy Brief 2.**

Domain 2: Cultural sensitivity

Cultural sensitivity generally refers to heightened awareness and complements several other domains, most notably communication. Lister defines cultural sensitivity as regard for a consumer's beliefs, values, and practices within a cultural context and awareness of how a provider's background may influence professional practice.[16] Cultural sensitivity also refers to some of the less readily quantifiable aspects of care with regard to culture. For instance, Hennessy and Friesen discovered that Mexican-Americans were highly concerned with the "caring" with which service was delivered, more than the technical proficiency of the care.[28]

Non-verbal communication, visual representation, and non-translated culturally-sensitive materials are examples derived from the literature of cultural sensitivity related to communication.[9,29,30,31] Though these topic areas also align with the domain of communication, their evolution from a finely tuned understanding of culture-specific needs and preferences beyond language needs merits their inclusion here.

- Salimbene discusses how providers and consumers use a "cultural filter" to process a host of information, including facial expressions, body language, and behavior, in provider-consumer interaction.[15]
- Wright, et al. study similar issues about non-verbal communication in relation to critical care patients making end-of-life decisions across a range of racial and ethnic groups. They observe how non-verbal cues are often critical in decision-making and how misunderstandings of these cues can lead to decisions around which little agreement exists.[32]
- Yancey and Waldlen describe the success of using Spanish-language videotapes in increasing breast and cervical cancer screening among Latinas and African-American women. These videotapes included relevant cultural dynamics, varied production elements with entertainment value (e.g., music), information comprehensible to an audience with little formal education, and a minimally didactic presentation.[33]
- Guidry, et al. analyze culturally sensitive printed cancer education materials targeted at African Americans, gauge their educational value[34] and discuss the need for

[28] Hennessy LL, Friesen MA (1994). Perceptions of quality of care in a minority population: a pilot study. **Journal of Nursing Care Quality**, 8, 32-37.

[29] The New York State Office of Mental Health. The Research Foundation for Mental Hygiene (1998 September). **Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs**. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[30] National Health Policy Forum (1997). **Issues Brief: Cross-cultural Competency in a Managed Care Environment.**

[31] Tirado M (1996 January). **Tools for Measuring Cultural Competence.**

[32] Wright F, Cohen S, Caroselli C (1997 March). Diverse decisions: how culture affects ethical decision-making. **Critical Care Nursing Clinic of North America**, 9, 1.

[33] Yancey AK, Waldlen L (1994). Stimulating cancer screening among Latinas and African-American women. **Journal of Cancer Education,** 9(1), 46-52.

[34] Guidry JJ, Fagan P, Walker V (1998). Cultural sensitivity and readability of breast and prostate printed cancer education materials targeting African-Americans. **Journal of the National Medical Association**, 90(3), 165-169.

cultural sensitivity to encompass the culture-specific needs and preferences of those populations for whom English is the primary language of communication.

Domain 3: Communication

Communication encompasses a wide range of activities that describe the flow and exchange of information among those involved in the provision and receipt of care. This focuses primarily on interpersonal exchanges between consumers and individual providers and the exchange that occurs between consumers and health care delivery organizations. The literature discusses a number of concerns regarding communication and how cultural factors may affect the consumer-provider communication,[35] including issues related to communication style, language services available to consumers, and language-concordant capacity of providers.

Consumers and providers each possess independent styles of communication.[36] There is evidence that having a sufficient number of administrative and provider staff competent in negotiating the communication styles of racial and ethnic groups seeking services can help minimize the need for interpreters and other language services.[10] Peer education and testimonials are other mechanisms to communicate across different styles.

- In studying how to increase breast and cervical cancer screening rates for African-American, Latina, Chinese, and Vietnamese women, Pasick, et al. discuss the importance of peer education and testimonials. Specifically, they examine different videos and printed brochures employed by a variety of clinics to determine the preferences of specific populations in terms of what information is important for them, how that information should be crafted into a message, and the different media preferences of the various populations.[37]
- DiClemente and Wingwood conducted the first randomized controlled trial of community-based HIV sexual risk reduction for economically disadvantaged young adult African American women and found that those who participated in peer education sessions on a variety of topics demonstrated significant improvement in some risk factors relative to their control group counterparts.[38]

Open communication between the provider, consumer, and the consumer's family is also critical to gaining understanding between providers and consumers with different communication styles.

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[35] Perez-Stable E, Napoles-Springer A, Miramontes J (1997). The effects of ethnicity and language in medical outcomes of patients with hypertension or diabetes. **Medical Care**.

[36] Baker C (1997). Cultural relativism and cultural diversity: implications for nursing practice. **Advances in Nursing Science**, 20(1), 3-9.

[37] Pasick RJ, D'Onofrio CN, Otero-Sabogal R (1996). Similarities and differences across cultures: questions to inform a third generation of health promotion research. **Health Education Quarterly**, 23, S142-161.

[38] DiClemente RJ, Wingwood GM (1995). A randomized controlled trial of an HIV sexual risk reduction intervention for young African-American Women. **JAMA**, 16, 1271-1276.

- Oomen and Owen, in examining how to identify and treat Type II diabetes among Latinas, suggest that providers ask direct questions on follow up visits regarding treatment adherence, barriers to compliance, and possible solutions.[21]

Language services for those consumers with limited English proficiency or for whom English is not the primary language is of growing importance in making treatment decisions and ensuring appropriate care.[32,39] These include the provision and appropriate use of interpreters and translated materials, for educational and administrative purposes. The Culturally and Linguistically Appropriate Services (CLAS) standards stress the importance of interpreters in consumers' interactions with the health care delivery system.[9,30] The availability of interpreter services that is timely and of high quality is often a concern, and standards for this vary.[10,40] Family and friends are not adequate substitutes for trained interpreters who demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting and knowledge in both the terms and concepts relevant to clinical or non-clinical encounters.[9]

- Baker, et al. examine the use of interpreters in emergency departments, assessing how often they are used and who usually interprets and studies consumer and provider perceptions of the appropriateness of their use based on respective language capabilities. They find that regardless of provider competence in the consumer's language of preference, consumers tend to prefer the use of interpreters, except when the consumer is more comfortable in English than another language.[31]
- Randall-David and Pasick, et al. discuss some of the difficulties in selecting an interpreter and stress that providers require training and knowledge in order to work with one effectively.[37,41]

In addition to oral language services, the presence of translated materials helps meet the needs of limited English proficiency consumers.[21,42] Translated materials can include patient education resources and administrative paper work, including consent forms, and should be translated into primary language of communities served.[9,43, 27,37,44] The translation should minimize the use of medical and professional jargon and be tailored for the appropriate racial and ethnic sub-populations.[45] It is critical to test translated

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[39] Dana RH (1998). Projective assessment of Latinos in the United States: current realities, problems, and prospects. **Cultural Diversity and Mental Health**, 4(3), 165-184.

[40] Cultural Competence Strategic Framework Task Force, New York State Office of Mental Health (1997 September). **New York State Cultural and Linguistic Competency Standards.**

[41] Randall-David E (1989 June). **Strategies for Working with Culturally Diverse Communities and Clients.** Hemophilia Program, Maternal and Child Health Bureau.

[42] Velkin, NS (1994). **Implementing the Surgeon General's Action Agenda: To Improve Access to Care and Quality of Life for All Children with Special Health Needs and Their Families, Survey of SPRANS/ MCHIP Grantees.** Maternal and Child Health Bureau.

[43] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (1996 June. **Managed Care and Ethnic Minorities:** Working Group to Develop an Education Agenda.

[44] Maternal and Child Health Bureau (1991). **Improving services for culturally diverse populations; MCHB's Division of Services for Children with Special Health Needs Activities, FY 1990-1991.**

[45] Bravo M, Canino GJ, Rubio-Stipec M, Woodbury Farina M (1991 March). A cross-cultural adaptation of a psychiatric epidemiology instrument: the diagnostic interview schedule's adaptation in Puerto Rico." **Cult Med Psychiatry,** 15(1), 1-18.

materials prior to widespread use.[46] Also, direct service providers should gauge the literacy rate of the target population. High illiteracy would merit more use of interpreter services or other visual representations vis-à-vis printed materials.[47]

- The examination of educational interventions to increase cervical cancer screening among non-white elderly by White, et al. reveals that educational interventions increase the awareness and need for routine Pap testing among the elderly but leave consumers' questions about the most efficient way to obtain this care unanswered.[48] These findings highlight how providers need to be aware of their clients' informational needs and level of comprehension.

Another area widely discussed in the literature relates to language concordance and the linguistic capacity of direct service providers. The language ability of the consumer is important to consider in order to understand the need for interpreter services[9] and can be tracked through patient records.[10] Additionally, providers' reliance on their own language skills is often sub-optimal. Not being able to rely on the usual linguistic cues may disrupt the degree to which physicians can obtain informed consent and how physicians assess and evaluate symptoms and result in misdiagnosis.[49]

- Woloshin, et al. suggest bilingual phrase sheets for staff and consumers as one way to facilitate communication.[49]
- Fluency examinations and credentialing represent more rigorous methods to improve the skill of providers who assume interpretation roles.[10]

Domain 4: Policies and procedures

Several articles highlight the importance of policy in ensuring that consumers receive appropriate services and helping provider organizations to institutionalize cultural knowledge.[25,43,50,51] Policy development can occur in planning and governance, as well as creating provider incentives and grievance and conflict resolution processes. Defining the breadth of plan and provider networks and staffing also becomes relevant in a managed care setting. A precursor of policy development is a process to incorporate cultural competence language on policy statements, including strategic plans and contract requirements.[26] Caution should be exercised in policy development as this can serve as a barrier to care. Agencies or professionals that are "culturally blind" may believe that

[46] Gonzalez-Calvo J, Gonzalez VM, Lorig K (1997 December). Cultural diversity issues in the development of valid and reliable measures of health status. **Arthritis Care Research**, 6, 448-456.

[47] Baker DW et al (1996). Use and effectiveness of interpreters in an emergency department. **JAMA**, 275(10), 783-788.

[48] White JE, Begg L, Fishman NW, Guthrie B, Fagan JK (1993). Increasing cervical cancer screening among minority elderly: education and on-site screening services to increase screening. **Journal of Gerontological Nursing**, 19(5), 28-34.

[49] Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch HG (1995). Language barriers in medicine in the United States. **JAMA**, 273(9), 724-728.

[50] Community and Family Multicultural Workgroup. Washington State Department of Health. (1995 September) **Building Cultural Competence: A Blueprint for Action.** National Maternal and Child Health Resource Center on Cultural Competency.

[51] Gant LM. (1996 March) Are culturally sophisticated agencies better workplaces for social work staff and administrators? **Social Work,** 163(9).

they are implementing culturally competent policies and procedures when their policies may discriminate against different racial and ethnic groups and restrict access to services.[1]

Policy changes made at a system level can begin with changes to planning and governance procedures.[52] Planning and governance represents a means for organizations to incorporate cultural values and priorities in service delivery and to move from mission to implementation.[46]

- The CLAS standards discuss including strategic goals, plans, policies, and procedures as part of a comprehensive management strategy.[9]
- Other recommendations in the field for health care delivery organizations include the creation of a cultural competence plan that includes defined steps for its integration at every level of organizational planning and the related policy or procedural changes needed.[10]

The processes to recruit and retain clinical and non-clinical staff for provider networks also represent policy areas in which health care delivery organizations can choose to act. Several authors view recruitment, retention, and development of staff with cultural knowledge and skills as an element of a culturally competent program.[8,10,27]

- The CLAS standards recommend developing and implementing a strategy to recruit, retain, and promote a qualified, diverse, and culturally competent administrative, clinical, and support staff that represents the racial, ethnic, and other communities being served.[9,44]
- Several sources suggest that developing specific job descriptions for staff who work with consumers from diverse cultural groups or posting position descriptions and personnel/performance measures that include skill sets related to linguistic competence can also attract personnel with cultural skills and encourage professional development among current staff.[27, 53]

In the context of managed care, hiring processes may affect network breadth and thus face increased scrutiny.

- Rosenbaum, et al. discuss how managed care plans can employ policies that limit the care available to underserved populations and cite areas of concern such as definition of service areas, criteria for membership in provider networks, and segregation of networks for publicly-insured consumers.[54]

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[52] National Latino Behavioral Health Workgroup, Western Interstate Commission for Higher Education (WICHE). (1996 December) **Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations.** Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[53] State CSHCN Title V Director Workgroup. (1990) **Improving State Services for Culturally Diverse Populations**. Maternal and Child Health Bureau, Department of Health and Human Services.

[54] Rosenbaum S, Serrano R, Magar M, Stern G. (1997) Civil Rights in a Changing Health System. **Health Affairs**, 16(1), 90-105.

Creating incentives for providers and grievance and conflict resolution processes for consumers is another important policy area that can influence the cultural competence efforts of an organization. Sanctions and incentives can encourage culturally competent behavior, measuring issues like culture-related complaints and grievance, and should decrease over time as situations change.[10] In terms of grievance and conflict resolution, the CLAS standards suggest developing institutional structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty accessing or denial of services.[9]

Domain 5: Training and staff development

Training and staff development refer to the ways in which provider organizations can develop cultural competence among health care providers and other staff involved in the provision of care. Articles discuss the importance of training providers in culturally and linguistically appropriate communication and identify measures and standards to ensure that this type of training as well as training in cultural knowledge occurs.

At its heart, the objective of training is that providers will reach a state of "cultural knowledge" and develop "cultural skill." Cultural knowledge means the "student begins to show familiarity with the broad differences, similarities, and inequalities in experience, beliefs, values, and practices among various groupings within society."[55] To reach this stage of familiarity and competence with other cultures the provider must be able to identify and have the ability to understand the cultural worldview and theoretical/ conceptual framework of patients from different cultures.[12] For the most part, the necessary methodologies and tools to reach this level of cultural knowledge draw from the fields of clinical ethnography, field study and systems approaches as exhibited in anthropological research.[56] This knowledge forms the base of what is known as "cultural skill," where the provider has developed the skill set to access an individual's background and formulate a treatment plan that is culturally relevant.[12,56]

In designing cultural competence training, federal efforts to understand the standards for culturally and linguistically appropriate services discuss how health providers and health service agencies should require and arrange for ongoing education and training for administrative, clinical and support staff.[9] On-going training is integral to progressing towards cultural competence and must be supported by structured opportunities to learn. These opportunities can be based on a developed framework for cultural diversity educational programs.[1,12,30,57] Curricula should be broad based and explore the differences not only among ethnic groups but also among various social groupings defined according to gender, generation, lifestyle, and socioeconomic class.[16]

Self-assessment can play a valuable role in the process of working towards cultural competence. Self-assessment tools develop the capacity of the care provider to recognize that one's own culture and cultural perceptions play a role in the consumer-provider

[55] Tirado, M. **Monitoring the Managed Care of Culturally and Linguistically Diverse Populations.**
[56] Jones M, Bond M, Cason CL (1998). Where does culture fit in outcome management? **Journal of Nursing Care Quality**, 13(1), 41-51.

exchange. This in turn should lead to a better understanding of other cultures and the rewards of providing culturally competent care. The training curriculum should assist the caregiver in this process by providing tools for self-assessment.[8,12,41] The literature presents another method for achieving "self discovery" in training through structured opportunities to work with other cultures and ethnicities.

- Barton and Brown find that students working with migrant health communities reported deepening respect for cultural minority groups, were able to identify the differences in cultural norms, and recognized the rewards gained in their transcultural experience.[57]

Domain 6: Facility characteristics, capacity, and infrastructure

Providers should seek to provide services that are accessible to many different cultures in a location and environment that is accessible and supported by information systems that can track cultural data.[1, 12, 43] Accessibility extends to the physical environment in which care is provided and how it is culturally perceived.[6]

- Pasick, et al. in their study of the role of culture in health promotion focused on cancer screening for African-American, Latina, Chinese, and Vietnamese women find that many medical care settings and the location of community activities influence the degree to which women obtained care.[37]
- Wright, et al. consider the impact of physical space and surroundings in end-of-life decision making and address the how the cultural interpretation of space can affect these decisions.[32]

Information systems that allow providers to collect and track cultural data are also critical to facilitating health care delivery organizations' efforts to encourage cultural competence. These data systems should include the capacity to link records by ethnicity in a timely way that allows tracking of patients and protects confidentiality.[10]

- Looking at a selection of states, the Texas Department of Health concludes that one lesson in implementing cultural competence is the capacity to gather information and use that information for long-term planning.[25]
- The CLAS standards also discuss how health care providers should use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data to become informed about ethnic/cultural needs, resources and the assets of the community.[9]

Domain 7: Intervention and treatment model features

Interventions and treatment model features range from culturally and linguistically competent evaluation, diagnosis, treatment, and referral services to interactions with traditional healing belief and inclusive decision-making. Other treatment model features that influence whether consumers and providers interact in a culturally competent manner include care coordination and health benefit design.[10,52] Coordination of services and

[57] Barton JA, Brown NJ (1992). Evaluation study of a transcultural discovery learning model. **Public Health Nursing**, 9(4), 234-241.

case management at the community level is an area providers can use to address the needs of diverse populations, particularly to promote continuity of care.[53] Many authors suggest that cultural competence is linked to quality of care and enhances it.[1,6,7,43]

Multiple organizations and research efforts specify the need for culturally and linguistically competent evaluation, diagnosis, treatment, and referral services.[15,40,58]

- Herrick and Brown discuss the need for planning appropriate culturally competent mental health services for Asian-Americans to ensure that the underuse of mental health services by that population is not inappropriate underuse.[59]

Full and accurate patient histories are of particular interest and several authors introduce models and protocols for diagnosis that allow providers to take medical histories and conduct an initial assessment in a way that accounts for cultural, sociological, psychological, and biological factors, including the level of the consumer's acculturation.[3,6,7,21,23,60]

Several authors suggest the establishment of guidelines on a range of clinical issues, such as triage and assessment, care planning, treatment services, and case management.[52] These guidelines should avoid stereotyping through superficial master of culture-specific characteristics but should rather build on evidence-based evaluation of cultural information identified through literature reviews and interactions with consumers.[61] Some authors suggest that providers have specialized assessment procedures for different racial and ethnic groups and include cultural factors in assessment protocols.[10]

- In their study of racial variation in cardiac procedure use and survival, Peterson, et al. find that African-American males treated at Veterans Affairs Medical Centers were less likely than their white counterparts to undergo selected cardiac procedures. Despite this difference in treatment received, African-American males experienced significantly higher survival rates than the white counterparts. However, the authors focus on the issue of whether standards of care differ by racial and ethnic group, regardless of outcome. The authors suggest several reasons for the differences in treatment, including differences in severity and consumer preferences but also differences in how providers may weigh the risk and benefit of invasive procedures differently for African-Americans than for whites.[62]
- Todd, et al. study analgesic use in emergency departments and find that ethnicity was the strongest predictor of the lack of use of analgesics. The authors suggest that providers may encounter difficulty recognizing pain in culturally different patients or

[58] Goiceochea-Balbona AM (1997). Culturally-specific health care model for ensuring health care use by rural, ethnically diverse families affected by HIV/AIDS. **Health and Social Work**, 22(3), 172-180.

[59] Herrick CA, Brown HN (1998). Underutilization of mental health services by Asian Americans residing in the United States. **Issues in Mental Health Nursing,** 19(3), 225-240.

[60] Bloch B. **Bloch's Assessment Guide for Ethnic/Cultural Variations.**

[61] Shapiro J, Lenahan P (1996). Family medicine in a culturally diverse world: a solution-oriented approach to common cross-cultural problems and medical encounters, **Family Medicine**. 28, 149-155.

[62] Peterson ED, Wright SM, Daley J, and Thibault GE (1994). Racial variation in cardiac procedure use and survival following acute myocardial infarction in the Department of Veterans' Affairs, **JAMA**. 271, 1175-1180.

that the presence of other decision-makers influence the provider's decision to administer pain relief.[63]

- Oomen and Owen, in looking at why Latinas with Type II diabetes often do not receive appropriate care, suggest that providers identify specific economic, social, familial and religious barriers to treatment adherence and modify treatment regimens accordingly.[21]

Including providers from multiple disciplines in care teams can facilitate interaction with ethnically diverse communities as well as assist in efforts to reach out to traditional healers.[64] Some authors emphasize the importance of cultural concordance between consumers and providers, such that consumers would receive services directly from either competent bicultural/bilingual personnel or personnel representing their own racial and ethnic group.[10]

- Goiceochea-Balbona discusses how an interdisciplinary group was able to respond to an HIV crisis in a rural community through bringing together the strengths of the team's respective disciplines and working with indigenous providers.[58]
- The Moy and Bartman study of 1987 NMES data reveals that minority patients were more than four times more likely to receive care from non-white physicians than non-Hispanic white patients and that individuals who received care from non-white physicians were more likely to report worse health.[65]

Obtaining an understanding of whether consumers are using traditional healers or other non-conventional care is important, particularly in the context of managed care where access to such services is often restricted.[8,21,31] Some authors encourage providers to reach out to traditional healers and encourage consumers to embrace traditional healing.[10,30]

- In 1990, almost nine out of ten respondents to a survey conducted by Eisenberg reported seeing a non-conventional provider without the recommendation of their medical provider.[66]
- Faculty at the Medical College of Pennsylvania instituted a four-hour session for second year medical students that introduced guidelines for eliciting information from and working with patients with traditional health beliefs and practices, citing the need to understand the prevalence of traditional beliefs and practices in their community.[67]

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[63] Todd KH et al. (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. **JAMA,** 1537-1539.

[64] Broughton BK, Lutner N (1995). Chronic childhood illness: a nursing health promotion model for rehabilitation in the community. **Rehabilitation Nursing,** 20(6), 318-322.

[65] Moy E, Bartman BA (1996). Physician race and care of medically indigent patients. **JAMA,** 273, 1515-1520.

[66] Eisenberg DM et al. (1993). Unconventional medicine in the United States: prevalence, costs, and patterns of use. **NEJM**, 328(4), 246-252.

[67] Rubenstein H et al. (1992). Introducing students to the role of folk and popular belief systems in patient care. **Academic Medicine,** 67(9), 566-568.

- The Massachusetts Chronic Disease Improvement Network suggests that providers recognize, accommodate, and integrate folk illnesses with biomedical treatments and also recommends working closely with decision-makers to identify, suggest, and explain biomedical alternatives to traditional practices.[23]

Input into decision-making regarding treatment represents another topic area related to intervention and treatment. Specifically, the literature's focus on involving the culturally appropriate decision-makers often concentrates on involving families.[31] Establishing agreement on the parameters of care can create an understanding of the diagnoses and securing compliance with treatment regimens.[10,21] This topic also relates to the domain of family and community participation but is included here to illustrate the importance of being inclusive in making treatment decisions.

- In examining state mental health services, Munoz and Sanchez discuss the importance of involving people from diverse backgrounds in setting provider agendas to encourage providers to gather input from consumers and their families.[8]

Domain 8: Family and community participation

Culturally diverse family participation at policy and program levels enhances the ability of providers and health care organizations to serve in a culturally competent manner.[10,42,64] Treatment should incorporate familial and community strengths in addition to individual strengths, and appropriate agency resources.[10]

- Davidhizar and Giger recognize the unique role of families and the differences in social organization in different cultures. They stress that providers should be sensitive to the family's role in patient care and encourage participation if appropriate.[6]
- Finley recognizes the role of families in caregiving and discusses the use of support models for families that build upon the strengths of families with diverse racial and ethnic backgrounds.[68]
- HRSA's Maternal and Child Health Bureau suggests steps that health care delivery organizations can take to involve families more intimately in the care process consisting of including extended family in family/provider meetings and conferences and arranging meetings that are convenient and comfortable for families, particularly parents.[53]
- Blackhall, et al. summarize a study that examined differences in attitudes regarding informing consumers of a cancer diagnosis among various racial and ethnic groups. The authors find that although some groups believe the consumer should be aware of the diagnosis, others rely on the family to make the decision as to whether and where to inform the consumer of the diagnosis and treatment option.[69]

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[68] Finley LY (1998 Winter). The cultural context: families coping with severe mental illness. **Psychiatric Rehabilitation Journal**, 21(3), 230-240.

[69] Blackhall LJ, Murphy S, Frank G, Michel V, Azen S (1995). Ethnicity and attitudes toward patient autonomy. **JAMA,** 271, 820-825.

- In the context of managed care, Starfield, et al. discover that consumers reported on a survey of satisfaction with primary care services better "family-centeredness" when they received services at a facility characterized by high degrees of limitation on physician autonomy or by capitation as compared to receiving services at a facility characterized by a low degrees of limitation on physician autonomy and non-capitated reimbursement.[70]

Reaching out to cultural groups can enhance providers' understanding of consumers' needs while developing their understanding of the location of the group, gaps in service, and barriers to care.[42] In assessing ways to improve the linguistic competence of primary care delivery systems, the National Center for Cultural Competence regards support of community outreach initiatives to persons with limited English proficiency as one way to gauge progress.[27] Developing relationships with key persons in the community helps providers to learn about the cultural values, beliefs, and practices of the community and provides a vehicle for community members to participate in the health care delivery system.[41]

- Goiceochea-Balbona discusses how reaching out to key traditional healers was a critical component in the success of an effort to respond to an HIV crisis in a rural community.[58]
- The CLAS standards include recommendations to use formal mechanisms for involving communities and consumers in service delivery design and execution, including planning, policy-making, operations, evaluation, training, and, as appropriate, treatment planning.[9]

Domain 9: Monitoring, evaluation and research

Monitoring and evaluation are critical to becoming culturally competent because it highlights areas of progress and needed improvement. This includes organizational assessment and an evaluation of consumer satisfaction and perception and use of services. In addition to evaluation, creating and disseminating new knowledge on cultural competence represents another arena for issues related to cultural competence.

Organizational assessment tools help both individual health practitioners and plan managers to better understand the process of delivering health care to culturally and linguistically diverse communities.[55] The literature implies that prior to conducting an organizational assessment, the organization should conduct a community needs assessment to be knowledgeable about the community it serves.[25] Additional evaluations should span multiple stakeholders and integrate measures of access, satisfaction, quality and outcome for culturally and linguistically appropriate services into internal audits and performance improvement programs.[25]

[70] Starfield B, Cassady C, Nanda J, Forrest CB, Berk R (1998). Consumer experiences and provider perceptions of the quality of primary care: implications for managed care. **Journal of Family Practice**, 46(3), 216-226.

- The CLAS standards suggest that organizations and providers should prepare an annual report documenting the organizations' progress with cultural competence, including information on programs, staffing, and resources.[9]

Analysis of consumer satisfaction and evaluation of services are also integral in providing culturally competent care.[40] This feedback is particularly important in managed care organizations and other organizations that monitor provider behavior. Possible methodologies include focus groups and a patient survey system to measure quality improvement.[71] The evaluation of specific services should also include a discussion of how culture affects health care.[30,72]

Exhibit II summarizes the references to the domains and sample topic areas by type of literature (e.g., core models and concepts, assessment tools and evaluative models, and program- and condition-specific studies).

This targeted review of the literature provides evidence for the nine domains of cultural competence and the topic areas within each of them. In the remainder of the report, these topic areas and domains are discussed with a focus on a measurement framework and potential indicators and measures.

[71] Carey RG, Seibert JH (1993). A patient survey system to measure quality improvement: questionnaire reliability and validity. **Medical Care**, 834-845.

[72] Roberson MK, Kelley JH (1996). Using Orem's theory in transcultural settings: a critique. **Nursing Forum**, 31(3), 22-28.

Exhibit II
Domains and Sample Topic Areas by Type of Literature

Domain	Topic Area	Core models and concepts (24 articles)	Assessment tools and evaluative models (40 articles)	Program evaluation and condition-specific studies (62 articles)
Values and attitudes	Acknowledges, respects	X	X	X
	Diversity		X	
	Mission, vision		X	
Cultural sensitivity	Non-verbal communication	X	X	X
	Visual representation		X	X
	Culturally sensitive encounters	X	X	X
Communication	Communication styles	X	X	X
	Interpreter		X	X
	Translated materials		X	X
	Linguistically competent organization		X	X
	Linguistic capacity of provider		X	X
	Language ability, oral and written, of consumer			X
	Provide information, education		X	X
	Administration and staff should be able to translate, cultural brokering		X	
Policies and procedures	Choice of health plan network		X	
	Choice of providers, provider network		X	
	Grievance and conflict resolution		X	
	Planning and governance		X	
	Adequate financing		X	
	Staff hiring, recruitment		X	X
	Incentive systems			X
	Policy development	X	X	X
Training and professional development	Training and professional development	X	X	X
	New staff orientations			
	Structured opportunities to learn	X		X
	Bilingual training			X
	Assessment of the knowledge and skills/ attitudes of the provider	X	X	X
	Cultural knowledge	X	X	X
	Knowledge of community needs			X
	Provider preparation	X	X	X
Facility characteristics, capacity, and infrastructure	Available and accessible services	X	X	X
	Physical environment, materials, and resources		X	X
	Information system			X

Exhibit II
Domains and Sample Topic Areas by Type of Literature

Domain	Topic Area	Core models and concepts (24 articles)	Assessment tools and evaluative models (40 articles)	Program evaluation and condition-specific studies (62 articles)
Interventions and treatment model features	Diagnosis, care planning, referral and treatment	X	X	X
	Culturally competent services		X	
	Cultural competence and quality of care	X	X	
	Culturally competent health benefit design		X	
	Culturally competent treatment plan		X	
	Culturally competent care	X	X	
	Input into treatment decision and service quality		X	X
	Use of medicines according to cultural belief, ethnopharmacology		X	X
	Use of traditional healers, healing methods	X	X	X
	Use of interdisciplinary teams			X
Family and community participation	Family centered care	X	X	X
	Community and consumer participation	X	X	X
	Family focus, family-oriented, recognition of the uniqueness of the role of the family	X	X	X
	Coalition-building			X
	Community outreach		X	X
Monitoring, evaluation and research	Consumer or member satisfaction and feedback	X	X	X
	Community needs assessment	X	X	X
	Organizational Assessment		X	
	Evaluation of health plans		X	
	Evaluation of services		X	
	Evaluation of provider		X	

Section III: Overview of the Measurement Framework and Identification of Specific Measures for Cultural Competence

III. OVERVIEW OF THE MEASUREMENT FRAMEWORK AND IDENTIFICATION OF SPECIFIC MEASURES FOR CULTURAL COMPETENCE

Previous sections of this report addressed the concept of cultural competence and the spheres or domains in which it should be manifested in health care settings and the topic areas within each domain. In looking towards the development of a measurement profile for cultural competence, we now turn to a presentation of a measurement framework, a structured way of thinking about the types of measures relevant to health care settings. We then use this framework to report findings from the literature on specific indicators and measures that might be applicable to measuring cultural competence. A more detailed display of these findings is presented in **Attachment 3**. This section of the report:

- Provides a description of the methodology used to review the measurement literature;
- Presents an overview of the measurement framework for cultural competence;
- Provides a description of the current state of the field in identifying measures and indicators of cultural competence by domain and;
- Discusses the different levels at which indicators and measures can be applied.

It is important to note that the measurement framework and specific indicators and measures reported in ***this section do not represent the final stage*** in developing a measurement profile of cultural competence. Rather, this serves as a starting point that will be further refined and informed by the input of key stakeholders (e.g., Technical Expert Panel, conversations with other experts, and site visits to health care delivery settings that employ innovative approaches to delivering culturally competent care). The description of measures used in the field of cultural competence presented here is continually being updated to capture a "universe" of performance measures that will be further refined and developed. In selecting from this "universe" of measures for the evolving measurement profile, consideration will be given to identifying measures that are meaningful, quantifiable, practical, and are useful to the variety of stakeholders interested in measuring cultural competence in health care settings.

A. Measurement literature review methodology

The review of the measurement literature included a review of assessment tools, standards and guidelines developed by and for specific stakeholders, and articles focused on measuring cultural competence. The literature identified either actual performance measures, provided suggestions of potential measurement areas, or described assessment tools. For the purposes of this report, these disparate types of information will all be classified as "measures."

Sources of measures or indicators of cultural competence were found across a variety of literature, both federal and non-federal. Federal agencies, including the Centers for Medicare and Medicaid Programs (CMMP, formerly the Health Care Finance Administration), the Department of Health and Human Services' Office of Minority

Health (OMH), and the Substance Abuse and Mental Health Services Administration (SAMHSA), have sponsored studies to identify measures of cultural competence for various health settings. For example, CMMP sponsored a report to develop a set of recommendations for measures of cultural competence for managed care organizations that provide care to Medicare and Medicaid beneficiaries under contracts with CMMP or with State Medicaid agencies.[73] SAMHSA has also sponsored studies to develop measures by which managed care organizations could be assessed on cultural competence.[74] DHHS' OMH sponsored a study that developed consensus and standards regarding what constitutes cultural and linguistic competence in health care service delivery (i.e., CLAS).[75] Other federal sources include works by DHHS' Health Resources and Services Administration (HRSA). Among these are a set of measures applied by HRSA's Maternal and Child Health Bureau to review potential and existing grantees for cultural competence.[76] The project team also reviewed criteria used in HRSA's Cultural Competence Works competition to recognize exemplary HRSA-funded programs for their culturally competent services[77] and programs highlighted by HRSA's Bureau of Primary Health Care as innovative in delivering services that bridge the cultural gap between providers and patients.[78] The innovative activities performed by these programs were reviewed to identify indicators of cultural competence that could serve as the basis for developing actual measures of cultural competence. The project team also reviewed tools developed by various authors and programs to assess the cultural competence of personnel and to conduct organizational assessments of cultural competence. For example, the National Center for Cultural Competence (NCCC) has developed a series of self-assessment tools for use by providers and organizations.[79] Authors such as Flores, G., Mason, J.L., Lavizzo-Mourey, R., Mackenzie, E.R., and Tirado, M. have also

[73] Abt Associates (2000). **Report on recommendations for measures of cultural competence for the quality improvement system for managed care.** Prepared for the Health Care and Financing Administration. Washington, DC.

[74] Center for Mental Health Services (1998). **Cultural competence standards in managed mental health care: Four underserved/underrepresented racial/ethnic groups.** Prepared for the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Purchase Order No. 97M047622401D.

[75] Office of Minority Health (1999). **Assuring cultural competence in health care: Recommendations for national standards and outcomes-focused research agenda.** Recommended Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care Services. Prepared for the U.S. Department of Health and Human Services. Washington, DC.

[76] Maternal and Child Health Bureau (1991). **Improving services for culturally diverse populations; MCHB's division of services for children with special health needs activities, FY 1990-1991.** Bureau, Health Resources and Services Administration, Department of Health and Human Resources. Washington, DC.

[77] Health Resources and Services Administration (2000). **Cultural Competence Works. Awards of Excellence.** "Certificates of Recognition Nominated Programs of Note" and "Certificate of Recognition." The Health Resources and Services Administration. U.S. Department of Health and Human Services. Washington, DC.

[78] The Bureau of Primary Health Care. (1999). **Cultural Competence: A Journey.** Health Resources and Services Administration, Bureau of Primary Health Care.

[79] Goode TD (1989. Revised 1993, 1996, 1999 and 2000) **Promoting cultural and linguistic competency. self-assessment checklist for personnel providing services and support to children with special health needs and their families.** Georgetown University Child Development Center- National Center for Cultural Competence (NCCC). Washington, DC.

developed either tools or models for measuring cultural competence. [80] [81] [82] [83] Refer to the Annotated Bibliography for a description of these and other sources used to identify measures and **Attachment 3** for a comprehensive listing of measures.

B. Overview of the measurement framework

Considering issues related to the structure, process, and outcome of care is a well-established and useful way of thinking about measurement in the health field, especially as related to assessing quality of care.[84] Building on this formulation, we add an additional area of assessment, "organizational viewpoint," and use four categories, described below, as a measurement framework by which to describe the types of measures applicable to cultural competence found in the literature. This framework provides one way of addressing the questions. "How do you know cultural competence when you see it?" You should know it, in part, by an organization's structures, processes, outcomes and viewpoint.

Type of measure

- **Capacity/structure measures**: assess the organization's capability to support cultural competence through adequate and appropriate settings, instrumentalities and infrastructure, including staffing, facilities and equipment, financial resources, information systems, governance and administrative structures, and, other features related to organizational context in which services are provided.
- **Process measures:** assess the content and quality of activities, procedures, methods and interventions in the practice of culturally competent care and in support of such care.
- **Impact/outcome measures:** assess the contribution of cultural competence to the achievement of various levels of objectives (e.g., intermediate, ultimate), with respect to the provision of care, the response to care, and the results of care.
- **Organizational viewpoint measures:** assess the values, principles, perspectives, outlook, and organizational attitudes espoused and displayed by an organization as these relate to cultural competence.

Vantage point and usage

In addition, we include in the measurement framework categories for examining the different vantage points from which different measures can be examined. Measures can

[80] Flores G (1999). **A model of cultural competency in health care.** Progress Notes: A Newsletter of the Massachusetts Chronic Disease Improvement Network. The Massachusetts Chronic Disease Improvement Network, 3(1), 1-3.

[81] Mason JL (1995). **Cultural competence self-assessment questionnaire: A manual for users.** Portland State University, Research and Training Center on Family Support and Children's Mental Health. Washington State.

[82] Lavizzo-Mourey R, Mackenzie ER (1996). Cultural competence: essential measurements of quality for managed care organizations. **Annals of Internal Medicine**, 124, 919-921.

[83] Tirado M (1998 December). **Monitoring the managed care of culturally and linguistically diverse populations**. Health Resources and Services Organization. The National Clearinghouse for Primary Care Information , Washington DC.

[84] Donabedian A. (1988). The quality of care. How can it be assessed? **JAMA**. 260, 1743-1748.

be categorized in terms of the stakeholders to whom this measure would be of interest (e.g., payers, providers, etc.), the purposes for which these measures might be used (e.g., oversight, quality improvement, formative evaluation), and the level of analysis (e.g., individual, organization, health system, or societal) for which the measure might be useful.

Exhibit III provides a graphical depiction of the measurement framework which will be applied to identifying indicators and measures of cultural competence by domain and topic area. **Attachment 3** includes the comprehensive, categorized list of measures.

Exhibit III
Measurement Framework Summary Table

Domain	Topic Area	Measures/ Indicators	Type of measure				Vantage point	Usage	Citation
			Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint			

C. Measures by Type

A review of the literature found wide variation in the type of measures currently available to assess the domains of cultural competence, with a greater representation of process, capacity/structure, and organizational viewpoint, than outcome/impact measures. The following summarizes this variation and the types of measures are discussed according to their frequency. Refer to the Annotated Bibliography for a description of documents used to identify measures and **Attachment 3** for a comprehensive listing of measures.

- **Process measures:** Process measures were the most prevalent types of measures across all the domains. The communication domain included process measures focused on the use of interpreters and translated materials and the training and staff development domain assessed the number of staff trained in cultural competence. In the polices and procedures domain, there were process measures focused on ensuring cultural competence through ensuring proportionality of racial/ethnicity providers to consumers and hiring of adequate numbers of multicultural/multilingual staff. The intervention and treatment model domain and family and community participation domain included measures that demonstrated the inclusion of consumer input in the treatment development, planning and decision-making processes. **Exhibit IV** provides a sample list of measures found in the literature categorized by domain.

Exhibit IV
Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Interpreter	Yearly updated directory of trained interpreters is available within 24 hours for routine situations and within one hour or less for urgent situations.
Communication	Interpreter	Percentage of clients with limited English proficiency (LEP) who have access to bilingual staff or interpretation services.
Communication	Translated materials	Percent of clients who receive oral and written notices, including translated signage at key points of contact, in their primary language informing them of their right to receive no-cost interpreter services.

Exhibit IV
Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Linguistically competent organization	• # of trained translators and interpreters available • # of staff proficient in languages of the community
Communication	Language ability, written and oral of the consumer	Consumer reading and writing levels of primary languages and dialects is recorded.
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets which demonstrate effective service, equitable access and comparability of benefits for populations of racial/ethnic groups
Policies and procedures	Staff hiring, recruitment	• # of multilingual/multicultural staff • ratio by culture of staff to clients
Training and staff development	Training and professional development	• % of staff with cultural competence training. • % of staff attending ongoing cultural competence training. • % of ongoing cultural competence training completed.
Training and staff development	Training and professional development	Cultural competence training is part of the credentialing process for case managers.
Intervention and treatment model features	Diagnosis, care planning, referral and treatment	Client assessments are conducted in client's primary language.
Intervention and treatment model features	Culturally competent treatment plan	Indicators of culturally competent treatment plan in health plan: • The Treatment Plan reflects both consumer and family involvement in its development and agreement. The degree of family involvement depends on the wishes of the consumer. • The organization has a written policy and a demonstrated practice linking families to advocacy and education groups.
Intervention and treatment model features	Input into treatment decision and service quality	Indicators of culturally competent treatment plan in health plan: • The Treatment Plan reflects both consumer and family involvement in its development and agreement. • There is evidence in the Treatment Plan of the use of racial/ethnic community services and resources. • The Treatment Plan was developed with a culturally competent clinician or consultation from such a clinician • Consumer and family involvement and investment in the development of, and agreement with, the Care Plan. • Culturally defined needs addressed in the care plans of consumers from various racial/ethnic groups. • Leadership by racial/ethnic Mental Health Specialists in the care planning process for consumers from various racial/ethnic groups.
Family and community participation	Community and consumer participation	Degree to which families participate in key decision-making activities. • Family participation on advisory committees or task forces • Hiring of family members to serve as consultants to providers/programs • Inclusion of family members in planning, implementation and evaluation of activities

- **Capacity/structure measures**: These types of measures were widely dispersed across the various domain areas. Capacity/structure measures found in the communication domain focused on the amount of financial resources dedicated to interpretation and translation services, the conduct of audits of provider networks to measure the linguistic capacity of the provider, and availability to mechanisms to disseminate culturally competent information to consumers. In the policies and procedures domain, capacity/structure measures focused on whether organizations had governing boards or advisory committees composed of diverse ethnic/racial

/cultural groups, used creative financing mechanisms to ensure access to traditional healers in health plan benefit packages, or had mechanisms in place to track consumer grievances and complaints. Capacity/structure measures were also found in the facility characteristics, capacity and infrastructure domain with measures that assessed whether organizations had adequate mechanisms in place to maintain and track data on the ethnic/racial/cultural composition of its service population. Capacity/structure measures in the monitoring, evaluation and research domain focused on whether organizations had the infrastructure to: conduct self-assessments on cultural competence through internal audits; conduct evaluations of health plan decision-making based on enrollee ethnicity; or conduct culturally competent community need assessments. **Exhibit V** provides a sample list of measures found in the literature.

Exhibit V
Sample of Capacity/Structure Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education/promotion material.
Communication	Linguistic capacity of the provider	Ability to conduct audit of the provider network which includes the following components: • Languages and dialects of community available at point of first contact • # trained translators and interpreters available • # of clinicians and staff proficient in languages of the community
Communication	Provide information, education	• Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.
Policies and procedures	Grievance and conflict resolution	Organization has structures in place to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services or denial of services.
Policies and procedures	Grievance and conflict resolution	Organization has feedback mechanisms in place to track # of grievances and complaints and # incidents.
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policy-making and influencing groups, and consumers served reflects service area demographics.
Facility characteristics, capacity, and infrastructure	Available and accessible services	• Transportation is available from residential areas to cultural competent provider • Organization has the flexibility to conduct home visits and community outreach • Cultural competent services are available evenings and weekends
Facility characteristics, capacity, and infrastructure	Information systems	Capacity for tracking of access and utilization rates for population of different racial/ethnic groups in comparison to the overall service population.
Monitoring, evaluation and research	Organizational assessment	Ability to conduct ongoing organizational self-assessments of cultural and linguistic competence and integration of measures of access, satisfaction, quality and outcomes into other organizational internal audits and performance improvement programs.

- **Organizational viewpoint measures:** Organizational viewpoint measures were distinguished from process measures because they reflect an organization's attempt at changing the attitude, values, belief, communication and culture of an organization or understanding patient-specific values and beliefs. These measures were found in the cultural sensitivity, values and attitudes, and communication domains where measures and assessment tools examined an organization's or provider's ability to appreciate, value and respect, the culture of others, how patients view their own

health, as well as how to communicate effectively with different cultures. Organizations could demonstrate this ability through the development of culturally competent mission statements, the conduct of patient health beliefs inventory, and the appreciation and use of various communication styles. In the policies and procedures and training and staff development domains, there were examples of measures that assessed an organization's commitment to cultural competence through the incorporation of cultural competence targets in staff incentive systems and required demonstration by providers of respecting and valuing diverse cultures. **Exhibit VI** provides a sample list of measures found in the literature.

Exhibit VI
Sample of Organizational Viewpoint Measures by Domain

Domain	Topic Areas	Measures/Indicators
Cultural sensitivity	Culturally sensitive encounters	Conduct health beliefs inventory of patient to understand the patient's explanatory model for illness.
Values and attitudes	Appreciate, respect	Checklist from the National Center for Cultural Competence (NCCC) on Values and Attitudes. Indicate A= things I do frequently, B= things I do occasionally, C= things I do rarely or never. • I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs. • I understand that traditional approaches to disciplining children are influenced by culture. • I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills. • I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
Values and attitudes	Mission, vision	Mission/vision statement commit to the delivery of culturally and linguistically competent services.
Values and attitudes	Mission, vision	MCO self-certification that its mission statement/strategic vision support diversity and cultural competence.
Communication	Communication styles	Checklist from the NCCC on Communication style. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never. • For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions. • I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions. • I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency. • I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.
Communication	Linguistically competent organization	Interpreters and bilingual staff demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters.
Communication	Linguistically competent organization	Consumer education information respects cultures, reflects literacy levels and is in different formats
Communication	Administration and staff should be able to translate, cultural brokering	Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
Policy and procedures	Incentive systems	Demonstration of staff knowledge and skills regarding group values, traditions, expression of illness, cultural competence principles (e.g., credentialing and performance based testing).
Training and staff development	Assessment of the knowledge and skills/attitudes of the provider	Checklist to assess cultural competence of provider: • Demonstrate attitudes that indicate a respect for the consumer's immigration, migration, colonization, and acculturation experiences. • Demonstrate attitudes that indicate a respect for the diverse heritages, cultures, and experiences of consumers from the four groups. • Demonstrate attitudes that indicate a willingness to work with culturally, ethnically, and racially diverse populations.

- **Outcome/impact measures:** Outcome/impact measures represented the least prevalent type of measure found in the literature. There were measures in the communication domain that examined misdiagnosis and inadequate treatment planning resulting from inappropriate communication styles. Other outcome/impact measures focused on the impact of cultural competence on increased use of preventive services (e.g., increased mammography rates) among minority populations. In the intervention and treatment model features domain, measures were found that provided a checklist to assess the impact of specific interventions, such as outreach. However, these checklists usually measured impact of the intervention via process or capacity/structure types of indicators rather than health status improvement or other traditional outcome/impact measures. The monitoring, evaluation and research domain did include measures on consumer, member and family satisfaction with services. **Exhibit VII** provides a sample list of measures found in the literature.

Exhibit VII
Sample of Outcome/Impact Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Diagnosis, care planning, referral and treatment	Decrease in misdiagnosis and inadequate treatment plans resulting from failure to communicate effectively with consumers from various racial/ethnic groups.
Intervention and treatment model features	Diagnosis, care planning, referral and treatment	Deaths of infants and children aged 0 through 24 years enumerated by age, subgroup, race and ethnicity.
Intervention and treatment model features	Diagnosis, care planning, referral and treatment	The ratio of the black infant mortality rate to the white infant mortality rate
Intervention and treatment model features	Culturally competent service	Indicators of a culturally competent treatment services provided to minority members in health plan: • Consumer and family satisfaction with treatment services. • Inclusion of culturally specific activities and domains of daily living (e.g., housing, access to primary health care and maintenance, family role, behavioral/developmental, vocational/ educational/employment, and community tenure) in treatment services. • Rates of symptom relapse and recidivism into restrictive level of care or other restrictive placements. Benchmark: Comparable to overall population served and significant reductions over time. • Rates of medication side effects, adverse incidents, and utilization of latest pharmacological interventions. • Rates of adverse occurrences during treatment (e.g., suicide, homicide, self-injury, accidents, physical and sexual abuse) within comparable age groups. Benchmark: Comparable to overall population served and decreasing over time.
Monitoring, evaluation and research	Consumer/ member satisfaction and feedback	Satisfaction rates due to communication styles and linguistically competent services to racial/ethnic consumers.
Monitoring, evaluation and research	Consumer/ member satisfaction and feedback	• MCO assesses patient satisfaction and clinician satisfaction with access to alternative health practices • MCO assesses patient and clinician satisfaction with access to team-based care including participation of caregivers from diverse communities.

D. Type of Measure by Level of Analysis

Another aspect of potential measures of cultural competence is provided by examining the different levels of analysis to which the measures could apply or the perspectives from which they can be viewed. This is related to looking at measures for vantage point and usage.

In health services research, the traditional levels of analysis are the individual, organizational, and societal level. For the purposes of this study, an additional level of analysis is critical - the health care delivery system. Following is a review of selected process measures and capacity/structure measures by these levels of analysis to illustrate how the same measure can be viewed from various perspectives.

Examples of Process and Capacity/Structure Measures at Different Levels of Analysis

Process measures are typically viewed as measuring internal practices and activities that are believed to be related to specific outcomes. As one would expect and is demonstrated in **Exhibit VIII**, many of the process measures could easily be analyzed at the organizational level. However, while process measures may actually be measured at the organizational level, their impact can also be analyzed at the individual and health care delivery system level. For example, the process measure of training clinicians in cultural competence practices can be analyzed at the individual level by: examining the satisfaction level of the individual patient who is receiving the services from the culturally competent trained clinician; or assessing the change in the individual behavior and values of the clinician due to his/her training.

In addition, process measures that focus on the production and availability of translated materials can be analyzed at the health care delivery system level to assess the potential change in the delivery system via improvements in the quality of access points (i.e., culturally competent communication via translated materials may promote improved access). Similarly, process measures that focus on policies regarding contractual arrangements with health plans can be analyzed at the delivery system level to highlight potential changes in non-clinical aspects of the delivery system, such as insurers adopting culturally competence practices.

In reviewing capacity/structure measures, there is also the potential for multiple levels of analysis. Because many of the capacity/structure measures are focused on infrastructure, these measures would be analyzed at an organizational level of analysis. However, these measures can also be analyzed from other perspectives. For example, measures that assess an organization's capacity to develop and maintain information systems to capture and track relevant data pertaining to cultural competence could be analyzed to gauge the impact of these efforts on the health care delivery system via increased information sharing and linkage of various components of the health care delivery system. Similarly, measures that assess an organization's capacity to provide transportation services or provide outpatient services at convenient hours of operation can also be analyzed at the health care delivery system level to reflect the potential for creating flexible venues of care. In addition, measures that assess an organization's capacity to conduct community needs assessment and create governing boards that reflect the influence of various consumer groups could be analyzed at the individual level to reflect the individual needs, values and perspectives of the local community. Refer to **Exhibit VIII** for a demonstration of how the discussed process and capacity/structure measures can be analyzed at multiple levels of analysis.

Exhibit VIII
Sample of Process and Capacity/Structure Measures by Level of Analysis

Domains	Topic Areas	Measures/Indicators	Level of Analysis			
			Individual	Organization	Health Care Delivery System	Societal
Process Measures						
Training and staff development	Training and professional development	Percentage of staff receiving at least five hours of training annually in cultural competence awareness.	X	X		
Training and staff development	Training and professional development	• % administrative staff with cultural competence training • % of administrative staff attending ongoing cultural competence training	X	X		
Communication	Translated materials	Percent of clients who receive oral and written notices, including translated signage at key points of contact, in their primary language informing them of their right to receive no-cost interpreter services.		X	X	
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets which demonstrate effective service, equitable access and comparability of benefits for populations of racial/ethnic groups.		X	X	
Capacity/Structure Measures						
Facility characteristics, capacity and infrastructure	Information systems	Having a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in service area and become informed about the ethnic/cultural needs, resources and assets of the surrounding community	X	X		
Facility characteristics, capacity and infrastructure	Available and accessible services	• Transportation available from residential areas to cultural competent provider • Culturally- competent services available evenings and weekends		X	X	
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policy-making and influencing groups, and consumers served reflects service area demographics	X	X		
Monitoring, evaluation and research	Community needs assessment	Organization has the capacity to conduct community profiles containing information on the percentage of the following that characterize target population: • % cultures • % age and % gender • % religions • % refugees and immigrants • % income distribution		X	X	

Section IV:
Conclusion

IV. CONCLUSION

A. Review of findings from the literature

This literature review report reflects an analysis of over 120 works in the field of cultural competence in health care and forms the basis for the development of a measurement profile for cultural competence in health care delivery settings. The literature reviewed includes seminal works that illuminate core concepts of cultural competence, as well as other literature examining specific assessment protocols or program and condition-specific issues. In analyzing this literature, The Lewin Group identified a preliminary set of nine domains for measuring cultural competence that emerged as core clusters from the array of theoretical and methodological concepts and approaches presented in the literature.

For each domain, specific indicators and measures were also identified from the literature. In reviewing the indicators and measures identified in the literature and their linkage with particular domains and topic areas, there was evidence of differing representation of measures by type of measure and across various domains and topic areas. In terms of measure type, the majority of measures in the literature can be classified as process oriented, with far fewer falling into the category of outcome/impact. The abundance of process measures and paucity of outcome/impact measures may be due to a variety of factors, including a lack of infrastructure to support data collection on outcomes. Process measures typically reflect the operational functioning of an organization and, hence, may represent data already being collected by an organization. The collection of outcome/impact measures often requires more sophisticated data collection techniques, additional resources, and may be impeded by privacy and confidentiality concerns. The lack of outcome/impact measures may also be due to the difficulty in parsing out the contribution of cultural competence to ultimate outcomes relative to other factors.

Measures were identified for almost all of the domains, with the exception of cultural sensitivity. Cultural sensitivity, though stressed in the core models and methods literature, was the least represented in the collection of health system measures. It is unclear to what extent this represents an actual gap in the field of study or points to overlap in how measures are constructed. It may be the case that the domain of cultural sensitivity and its attendant topic areas are imbedded or captured adequately through other domains.

In general, the review and analysis of the literature highlighted critical elements to be measured in health care delivery setting and potential areas for measurement. However, while the literature contains many examples of standards and guidelines that can be translated into performance measures, as well as tools that can be used in assessing cultural competence in various health care delivery settings, the literature containing tested and validated measures of cultural competence is limited. This lack of validated and broadly applied measures represents a significant challenge for the further development of a measurement profile.

B. Implications for developing a measurement profile

While the literature review provided support for what constitutes the critical elements (i.e., domains) of cultural competence, in order to further refine and develop a measurement profile of cultural competence, the field must move beyond conceptualizing cultural competence to applying and testing actual measures of cultural competence in real-world settings. Before an empirically-tested measurement profile can be developed, several challenges need to be considered, both generic to measurement and specific to measuring cultural competence.

Measurement Challenges Specific to Cultural Competence

- **Fluid and multi-faceted nature of culture and cultural competence:** Culture is typically characterized as a monolithic, unitary phenomenon that remains stable over time and homogenous within different social groups. However, in actuality both culture and cultural competence are fluid and dynamic constructs and processes. This may pose a dilemma for measuring cultural competence given the requisite concreteness of measurement and the fluid nature of cultural competence.
- **Complexity of culture and cultural competence:** Along with the issue of fluidity is the need to consider the complex nature of culture and cultural competence. Culture and cultural competence as multi-faceted constructs will require a measurement approach that captures not only fluidity, but also its relationship to and interaction with an individual, organization, health care delivery system, and society.
- **Attribution:** Cultural competence is an essential component of a larger set of variables important for improving access, eliminating health disparities or impacting other types of outcomes. Due to the multiplicity of factors that influence these outcomes, it becomes difficult to parse out the contribution of cultural competence in the larger context of other factors.

General Measurement Challenges

- **Organization's appreciation of the value of measurement:** One of the key challenges to measurement is garnering the organizational will to pursue activities around measurement. Organizations must first recognize the value of measurement and view it as an integral component of their operational functioning. Without "buy-in" from every level of an organization as to the importance of measurement, forward momentum may be stalled and derailed.
- **Data availability and feasibility:** While a measure may be deemed important for measurement, without an existing data source further progress is delayed. A corollary data challenge in measurement is the issue of feasibility. Data collection may not be feasible due to the burden associated with additional staffing requirements and available financial resources.
- **Baseline data:** Related to the issue of data availability and feasibility is the lack of adequate baseline data to support measurement. Baseline data and an adequate assessment of the current environment are necessary for setting targets and assessing change and impact. Without adequate baseline data, the timeline for proceeding with measurement may be delayed until additional resources are identified to collect it.

- **Capacity of health care delivery organizations for measurement:** Many organizations are not equipped to invest in measurement. Organizations may lack the infrastructure needed to engage in measurement activities, such as information technology, dedicated staff, record keeping, etc. It may be necessary for organizations to do an internal scan of their capacity to engage in measurement efforts and either identify, direct or re-direct the necessary resources.
- **Instrumentation and tools:** The evolution of more sophisticated measures must coincide with the evolution of appropriate instrumentation and tools. Existing measurement tools may not be able to capture the nuances of specific measures. Various tools such as surveys and interviews have inherent limitations that may impact their usefulness for measuring difficult concepts within cultural competence.
- **Short term versus longitudinal measurement issues:** In assessing the value of process versus outcome types of measures, many prefer outcome measures because of their potential to demonstrate direct and concrete impacts of various activities. However, while outcome measures may be preferred, they are much more difficult to measure and their impact may not be readily identifiable in the short term. The use of outcome measures may require longer time horizons to demonstrate impact.

The purpose of this literature review report and the overall HRSA project is to serve as a building block for advancing the *practical* understanding of how to measure cultural competence in health care settings. An important next step includes refining the identified domains and identifying areas where domains and topic areas could be collapsed. Important next steps toward assessing the feasibility and practical application of potential measures include identifying: a limited core set of indicators/measures; ways to translate and apply these measures in health care settings; potential data sources and approaches for obtaining information on these indicators and measures; existing and needed instruments and tools for gathering information on the identified indicators and measures of cultural competence; and the infrastructure necessary to support measuring cultural competence in health care delivery settings. Gathering information from health care delivery settings on the appropriateness and feasibility of the measurement profile will advance the science of measuring cultural competence in health care delivery settings by addressing the question, "How do we know cultural competence when we see it?"

Attachments for the Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings

A Review of the Literature

Attachment 1: Annotated Bibliography
Attachment 2: Criteria for Literature Review
Attachment 3: Potential Measures/Indicators of Cultural Competence

Prepared for:

The Health Resources and Services Administration

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Acknowledgements:
Willine Carr, HRSA Project Officer
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Attachment 1:
Annotated Bibliography

ATTACHMENT 1: ANNOTATED BIBLIOGRAPHY

Core Models and Methods

Baker C (1997). Cultural relativism and cultural diversity: Implications for nursing practice. **Advances in Nursing Science**, 20(1), 3-9.

This article examines the doctrine of cultural relativism in nursing practices. Cultural relativism is defined as the perspective that the behaviors of individuals should be judged only from the context of their own cultural system. The terms refer to the use of one's own culture as the starting point to judge other cultures and to the assumption that one's own culture is superior to other cultures. The article examines the dilemmas faced by nurses in making judgments in cross-cultural situations and suggests drawing on the hermeneutic approach as a philosophy for cultural encounters. The hermeneutic approach deals with how one person comes to understand the actions, words, or any other meaningful product of another person. At the heart of the hermeneutic perspective is constructive communication across cultures.

Brink PJ (1999). Transcultural versus cross-cultural. **Journal of Transcultural Nursing**, 10(1), 7.

The article is a short discussion of the terms transcultural and cross-cultural. It defines transcultural as the belief in concepts that transcend cultural boundaries. In contrast, the author places cross-cultural in the context of anthropological research that compares and contrasts cultural groups with each other.

Campinha-Bacote J (1994). **The process of cultural competence in health care: A culturally competent model of care**. Perfect Printing Press. Wyoming, OH.

Campinha-Bacote presents a culturally competent model of care with four components on a continuum: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill and (4) cultural encounters. Cultural awareness is defined as having cultural sensitivity and avoiding cultural biases. Cultural knowledge is defined as the care provider understanding the cultural would view and theoretical/conceptual framework of the patient. Cultural skill is defined as the provider having developed the skill-set to access an individual's background and formulate a treatment plan that is culturally relevant. Cultural encounters are the processes which allow the health care provider to directly engage in cultural interaction with clients from culturally diverse backgrounds. Additionally the article provides a checklist of the "Six A's for Culturally Responsive Services" as a as keys to providing access of services to underserved and culturally/ ethnically diverse populations. The six A's are: (1) available, (2) accessible, (3) affordable, (4) acceptable, (5) appropriate, and (6) adoptable.

Campinha-Bacote J (1999). A model and instrument for addressing cultural competence in health care. **Journal of Nursing Education**, 38(5), 203-207.

This article presents the author's Inventory to Assess the Process of Cultural Competence (IAPCC) among healthcare professionals, an instrument that measures the constructs of cultural awareness, cultural knowledge, cultural skill, and cultural encounters among health care professionals. The IAPCC is a self-

administered survey that uses a 4-point Likert scale to score 20 different items. These 20 items address each of the four constructs. The full instrument is not included.

Carballeira N (1997). The LIVE and LEARN model for cultural competent family services. **Continuum**, 17(1), 7-12.

The author applies a model of cross-cultural attitudes to shed light on what happens whenever a provider and a client from different cultures meet. The author suggests that whenever the provider manifests a cultural attitude, the client exhibits some reaction. The model of cross-cultural attitudes and client reactions fall in a range from superiority – incapacity – universality – sensitivity – to competence, whereas the client reactions range from resistance – accommodation – to adaptation. The author proposes the LIVE & LEARN model which stands for: *Like- Inquire – Visit – Experience and Listen – Evaluate – Acknowledge – Recommend – Negotiate.* The model presents providers with a practical, phased approach to cross cultural service delivery that respects client centrality, avoids stereotyping, and leads to the adoption of mutually acceptable objectives and measures for changed behavior.

Cross TL, Bazron BJ, Dennis KW, Isaacs MR (1999). **Toward a culturally competent system of care, volumes 1 and 2.** National Institute of Mental Health, Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Georgetown University Child Development Center. Washington, DC.

This monograph outlines a philosophical framework for developing and implementing a service delivery system that provides services in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups. The authors developed a comprehensive cultural competence model that can be used to assist health care professionals to work effectively in cross-cultural situations. The monograph sets forth a six point cultural competence continuum and, outlines the five essential elements that contribute to a system's or agency's ability to become more culturally competent, and identifies a set of underlying values that must be present in a culturally competent system of care. In addition, the authors provide some practical ideas for improving service delivery at the policymaking, administrative, practitioner, and consumer level.

Klein A, Marie-Martinez R, Lacerino-Paquet N (1998). **Background paper for a national assessment of linguistically and culturally appropriate services in managed care organizations serving racially and ethnically diverse communities.** Prepared by Mathematica Policy Research, Inc. for the U.S. Department of Health and Human Services.

This article is a review of the current literature that defines and describes the nature and extent of linguistic and cultural appropriateness in health care and that links such services to patient and health outcomes. The paper provides a series of definitions for linguistically appropriate services, a discussion of the alternative language used for addressing the concept of cultural competence, and addresses the different service models of culturally appropriate care.

Jones M, Bond M, Cason CL (1998). Where does culture fit in outcomes management? **Journal of Nursing Care Quality**, 13(1), 41-51.

The authors describe the concept of cultural competence and ways in which culture is important to the delivery of culturally competent care. The authors propose strategies for developing a culturally competent work force; drawing lessons from on ongoing projects in the United States and the fields of clinical enthography and anthropological research.

Leininger M (1993). Towards conceptualization of transcultural health care systems: concepts and a model. **Journal of Transcultural Nursing**, 4(2), 32-40.

The Sunrise Model is a comprehensive guide for nurses to use in conducting a cultural care assessment. The model is based on six domains: (1) culture values and lifeways; (2) religious, philosophical, and spiritual beliefs; (3) economic factors; (4) educational factors' technological factors; (5) kinship and social ties; and (6) political and legal factors. It also describes three modalities that can guide nursing interventions so as to provide culturally appropriate care: (1) cultural care preservation and/or maintenance; (2) cultural care accommodation and/or negotiation; and (3) cultural care re-patterning or restructuring. Not all three modalities may be necessary to achieve cultural competent care.

Office of Minority Health (1999). **Assuring cultural competence in health care: Recommendations for national standards and outcomes-focused research agenda.** Recommended Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care Services. Prepared for the U.S. Department of Health and Human Services. Washington, DC.

This report responds to the need to develop consensus and standards regarding what constitutes cultural or linguistic competence in health care service delivery. This report outlines a set of 14 standards for use by various stakeholders, including providers, policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators and the health care community in general. The expectation is that the standards will provide guidance to providers on how to provide culturally competent care and provide policymakers and consumers with the tools to evaluate and assess whether a provider is delivering culturally competent care. The recommended standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. The process used in developing the standards included the formulation of research questions and a review of technical and policy literature to identify categories of cultural competence. A content analysis of the literature was conducted which identified two thematic clusters corresponding to (1) linguistic competence (i.e., language access, interpreter and translation services) and (2) cultural competence (i.e., patient, staff and organizational cultural diversity management). An initial list of 21 draft standards was consolidated to 14 standards. The standards relate to a variety of areas, including policies and organizational structures, consumer involvement, training and education of staff, and the provision of interpretation services. Along with recommended national standards, the report also outlines a research agenda for relating the standards to outcomes.

Pachter LM (1994). Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. **JAMA,** 271(9), 690-694.

This article presents an approach to evaluation of patient-held beliefs and behaviors that may not be concordant with those of medical doctors. Most clinical encounters can be analyzed as an interaction between the "culture of medicine" and the "culture of patients." These two groups have different beliefs, attitudes, and knowledge; physicians and patients often have different ways of conceptualizing a sickness episode. Illnesses that do not fit into any biomedical disease category are often called "folk illnesses". The authors present several reasons for health care providers to know about folk illnesses and suggest that clinicians need to become aware of commonly held folk beliefs, assess the likelihood of a patient acting on those beliefs, and arrive at a way to negotiate between the belief systems.

Pachter LM (1993). Folk illnesses: methodological considerations. **Medical Anthropology**, 15, 103-107.

This paper suggests that methodologies to study the concepts and beliefs behind illness are becoming increasingly sophisticated. Brief explanations of different methodologies cover exploration of the relationship between individual informant responses and underlying cultural beliefs; cross-cultural variation in folk-illness beliefs; and analysis of the interface between folk-illnesses and biomedicine. The author emphasizes that researchers need to constantly explore new methodologies when studying folk illnesses.

Resnicow K, Baranowski T, Ahluwalia JS, Braithwaite RL (1999). Cultural sensitivity in public health: defined and demystified. **Ethnicity and Disease**, 9(1), 10-21. Review.

This article describes various concepts that are related to cultural competence and draws from sociological and linguistics theory to delineate between two levels of cultural competence (surface and deep). In examining how to implement interventions, the authors suggest using focus groups and pre-testing.

Roberson MR, Kelley JH (1996). Using Orem's theory in transcultural settings: a critique. **Nursing Forum**, 31(3), 22-28.

This article presents a critical analysis of Orem's Self Care Deficit Theory of Nursing for use with culturally diverse populations. The article applies the theory to examples from multiple international communities, including two examples of communities in the United States (Navajo and Puerto Rican). The authors state the limitations of Orem's theory lie in the failure to include a discussion of how culture impacts health care, of what specific knowledge base is required to perform a cultural assessment, and of what needs to be incorporated into a cultural assessment.

Shapiro J, Lenahan P (1996). Family Medicine in a culturally diverse world: a solution oriented approach to common cross-cultural problems and medical encounters. **Family Medicine**, 28, 149-155.

This article identifies general strategies that can be applied by medical residents when approaching cross-cultural encounters. The authors caution against using the traditional "universalistic perspective," whereby cultural differences are all but ignored and interpretations and interventions inconsistent with a patient's

belief system are imposed on the patient. Instead, the authors explore the "culture-specific" model where residents begin to develop efficient, solution-oriented ways of using cross-cultural principles to guide patient-physician interactions. The authors caution against indulging in a simplistic "cultural elements" approach whereby residents are encouraged to become familiar with a vast array of cultural variation. Instead, the authors suggest: (1) evidence-based evaluation of cultural information whereby residents identify particular cultural constructs that have clear behavioral/social implications; and (2) inductive models of learning whereby the patient, rather than theory, is the starting point for discovery and residents observe patient behavior and form conclusions that apply to the patient.

Smith LS (1998 Spring). Concept analysis: cultural competence. **Journal of Cultural Diversity**, 5(1), 4-11.

This article examines the concept of cultural competence and attempts to clarify the term as used in health care literature that explores the race-culture comparative paradigm. The author describes various components of cultural competence including the events, ideas, conditions, and behavior that must occur for cultural competence to occur, and the consequences of cultural competence. The importance of developing methods for measuring cultural competence and the creation of empirically based standards for cultural competence are discussed.

Shumaker RP (1998). Multicultural needs bring on new opportunities. **AORN Journal**, 68(5), 744-746.

This is an editorial exploring the need for understanding transcultural care. In this article cultural competence is defined as the ability to deal with individuals on different levels, ranging from a transcultural assessment to identifying factors such as religious views or folk cures that may influence a patients behavior when ill.

Tirado M (1998 December). **Monitoring the managed care of culturally and linguistically diverse populations**. Health Resources and Services Organization. The National Clearinghouse for Primary Care Information , Washington DC.

This study develops culturally sensitive self-assessment tools which both individual health practitioners and plan managers can use to better understand the process of delivering health care to culturally and linguistically diverse communities. The tools were tested by a group of mental health care professionals to determine the relevance of the instruments in a variety of health care settings. With the collaboration of these groups, the professionals discussed the organizational challenges managed care plans face in seeking to address the needs of limited and non-English speaking members systematically. The study promotes "customized care" efforts that promote an individualized approach to caring for plan members and for supporting the professional staff assigned to serve them.

West EA (1993). The cultural bridge model. **Nursing Outlook**, 41(5), 229-234.

The authors explore the application of the cultural bridge model to providing nursing care to Native American Indians. The model is based on the concept of mutual respect and builds on the idea of maintaining cultural differences and uniqueness while having a meaningful relationship with people of differing cultures.

Assessment Tools and Evaluative Models[1]

Behui K, Bhugra D (1997). Cross-cultural competencies in the psychiatric assessment. **Journal of Hospital Medicine,** 57(10), 492-496.

This article outlines the essential features in contemporary psychiatric practice to which one must attend when patient and professionals do not share the same culture. The authors draw upon Kleinman's explanatory model that argues that patients have a unique set of beliefs about the causation of their change in function and emotional experience, and this determines who they think are appropriate care givers for the healing process.

Bravo M, Canino GJ, Rubio-Stipec M, Woodbury-Farina M (1991). A cross-cultural adaptation of a psychiatric epidemiology instrument: the diagnostic interview schedule's adaptation in Puerto Rico. **Culture Medicine and Psychiatry**, 15(1), 1-18.

This article illustrates the application of a comprehensive cross-cultural adaptation model of the Diagnostic Interview Schedule (DIS) to both the translation into Spanish and the adaptation to a population of Puerto Ricans.

Browne AJ (1997). A concept analysis of respect applying the hybrid model in cross-cultural settings. **Western Journal of Nursing Research**, 19(6), 762-780.

The article deconstructs "respect" as a concept in the domain of nursing using the hybrid model of concept development, illustrated with examples from two different cross-cultural settings. The authors point out that conveying respect during cross-cultural interactions, and to marginalized or disadvantaged patients, maybe be particularly challenging specifically because manifestations of respect may be dependent on culturally specific norms of interacting.

Broughton BK, Lutner N (1995). Chronic childhood illness: a nursing health promotion model for rehabilitation in the community. **Rehabilitation Nursing**, 20(6), 318-322.

This articles presents a model for culturally competent nursing that attempts to blend health education with achievable health promotion activities, while respecting cultural differences. It accounts for the interdisciplinary influence of care providers, community members, culture, the family, and the individual.

Campbell JC, Campbell DW (1996). Cultural competence in the care of abused women. **Journal of Nurse-Midwifery**, 41(6), 457-62.

This article discusses the principles of cultural competence, abuse, and empowerment as the basis for a model designed for nurse-midwives who provide clinical intervention to abused women. The discussion of cultural competence is based on models by Campinha-Bacote and Rorie, et al. The article concludes that nurse-midwives interact with women at a stage of life when they are particularly invested in family and children, and that a culturally competent assessment of the

[1] The areas of "assessment tools and evaluative models" and "performance measures and/or indicators" are organized into separate sections. This was done in order to distinguish between those documents that were consulted in developing a conceptual model of cultural competence and those consulted in identifying performance indicators and/or measures of cultural competence. There is some overlap of citations between these sections.

family unit enhances the probability of accurate assessment and effective intervention in care of abused women.

Campinha-Bacote J, Yahle T, Langenkamp M (1996 March-April). The challenges of cultural diversity for nurse educators. **Journal of Continuing Education for Nurses,** 27(5), 59-64.

The authors demonstrates how Campinha-Bacote's model can provide nurse educators with a framework for teaching nurses how to deliver culturally competent care. Cultural competence is defined as a process, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family, or community with a diverse cultural and ethnic background. The authors make recommendations for cultural diversity educational programs such as; considering the culture of the hospital setting prior to implementation; using teaching from a culturally competent instructor; being offered on a voluntary basis; incorporating creative and non-threatening experiential exercise (such as cultural bingo, humor therapy, etc); and providing a positive learning experience.

Carrillo JE, Green AR, Betancourt JR (1999). Cross-cultural primary care: A patient-based approach. **Annals of Internal Medicine**, 130(10), 829-835.

This article presents a structure for a cross-cultural curriculum that assists physicians in understanding how a patient's socio-cultural background affects his or her health beliefs and behaviors. The curriculum is grounded in ethnographic theory as well as medical interviewing techniques. The curriculum is comprised of a set of concepts and skills taught in 5 modules over four 2-hour sessions. Module 1 defines culture and assists participants in exploring their personal culture and the "medical culture" and discusses the attitudes that are fundamental to cross-cultural encounters. Module 2 explores "core cultural issues" or situations, interactions, and behaviors that have potential for cross-cultural misunderstanding. Module 3 focuses on patients' explanatory models of illness, how the participants can explore it with individual patients, and how it effects the physician-patient encounter. Module 4 assists participants in defining and managing the patient's social context, or the social factors that are most relevant to the medical encounter. The final module, the capstone of the training, draws on the skills learned in the previous modules and teaches participants to facilitate and negotiate cross-cultural encounters.

Community and Family Health Multicultural Workgroup, Washington State Department of Health (1995). **Building cultural competence: A blueprint for action.** Prepared by the National Maternal and Child Health Resource Center on Cultural Competency.

This report provides specific examples of effective state strategies in addressing the needs of diverse growing populations, as well as challenges that any state would face in this process. The report discusses the specific process followed by the Community and Family Health staff of the Washington State Department of Health. It is a blueprint that can be adapted to suit the specific needs of agencies. The report emphasizes that acquiring cultural competence is a process that requires participation at all levels of an agency from the individual to the organizational level. The report includes references the workgroups found useful

and appendices, which include relevant definitions, illustrations, guidelines and forms.

Cultural Competence Strategic Framework Task Force, New York State Office of Mental Health (1997). **New York state cultural and linguistic competency standards**. Prepared for the New York State Office of Mental Health. New York, NY.

This report is the result of a workshop in which participants worked to develop performance measures to assess compliance with cultural competence standards. The workgroup defined five domains of cultural competence: accessible inpatient, outpatient, and community support services; qualified interpreters; involvement of enrollees and families role in service development; culturally and linguistically competent evaluation, diagnosis, treatment and referral service; and membership satisfaction.

Cultural Competency Subcommittee for the Hispanic Agenda for Action, Department of Health and Human Services (1998). **Recommendations on cultural competency.** Prepared for the Department of Health and Human Services. Washington, DC.

This article represents the framework developed by a cultural competence subcommittee for the HHS 1998 Hispanic Agenda for Action initiative. The subcommittee cited the need for an HHS adopted definition of cultural competence, a coordinated HHS approach to cultural competence, and general awareness as reasons for its work. This article provides an inventory of cultural competence activities across HHS agencies that include: policies, mission/principles, standards, guidelines, performance measures, cultural competence workgroups and initiatives, provision of program information in languages other than English, employment of bilingual staff, training of staff on culturally diverse populations, language development courses, publications on cultural competence, and funding for cultural competence initiatives.

Davidhizar R, Giger JN (1998). Transcultural patient assessment: a method of advancing dental care. **The Dental Assistant,** 67(6), 34-43.

This article is an analysis of the Davidhizar and Giger model for cultural competent care in oral health services. The article emphasizes that it is essential for persons who work in a dental office to understand the differences in individuals from culture to culture. It is also important to appreciate that each patient and family is culturally unique and brings this uniqueness to the dental office.

DeSantis L (1994). Making anthropology clinically relevant to nursing care. **Journal of Advanced Nursing**, 20(4), 707-715.

This article examines the ability of transcultural nursing, a field that connects nursing with anthropology, to operationalize the concept of culture in order to develop culturally competent clinicians who are capable of knowing, using, and appreciating the effect of culture when providing care to the individual, group, community, or family.

Felder E (1990). The nursing cultural center, a design for cultural diversity. **The ABNF Journal : Official journal of the Association of Black Nursing Faculty in Higher Education, Inc**, 1(1), 7-9.

The article addresses the rationale for the development of the Nursing Cultural Center designed to effectively aid and train nurses and other health professionals to meet the challenges of cultural diversity in health care delivery. The article includes a cultural nursing center conceptual model as well as addressing five specific goals for the center, which have a general application to institutionalizing cultural competence in teaching hospitals.

Gonzalez-Calvo J, Gonzalez VM, Lorig K (1997). Cultural diversity issues in the development of valid and reliable measures of health status. **Arthritis Care Research**, 10(6), 448-56.

The article discusses the issues of measurement and assessment in cultural diversity research. The authors suggest that the development of instruments for use in culturally diverse settings and populations involve more then just translation. Measurements must be tested for content validity and appropriate meaning among members of the targeted group with careful attention to validity, reliability, and cross-cultural differences among cultures.

Like RC, Steiner RP, Rebel AS (1996 April). Recommended core curriculum guidelines on culturally sensitive and competent health care. **Family Medicine**, 28(4), 291-7.

This article outlines a proposed curriculum for family practice medical residents and students. The curriculum topics revolve around attitudes, knowledge, and skills. The article discusses the necessity of interspersing the training throughout a student's or resident's career.

Lister P (1999). A taxonomy for developing cultural competence. **Nurse Education Today**, 19(4), 313-318.

This paper proposes several elements to develop culturally competent practitioners: cultural awareness, cultural knowledge, cultural understanding, and cultural sensitivity. Cultural awareness is a state in which the student is able to describe how beliefs, values, and personal/ political power are shaped by culture, and that different cultures, subcultures and ethnicities may validate different beliefs and values. Cultural knowledge is a state in which the student begins to show familiarity with the broad differences, similarities, and inequalities in experience, beliefs, values, and practices among various groupings within society. Cultural understanding is a state in which the student recognizes the problems and issues faced by individuals and groups when their values, beliefs and practices are compromised by dominant culture. Cultural sensitivity is a state in which the student shows regard of an individual client's beliefs, values and practices within a cultural context, and shows awareness of how their own cultural background may be influencing professional practice. Cultural competence is a state in which the student provides or facilitates care which respects the values, beliefs, and practices of the client, and which addresses the disadvantages arising from the client's position in relation to networks of power. The authors suggest that the model could possibly be used to structure a curriculum that explores the

differences among various social groupings defined according to gender, generation, lifestyle, or class as much as ethnicity.

Matherlee K, Burke N (1997 September). Cross-Cultural Competency in a Managed Care Environment. National Health Policy Forum, George Washington University, Issue Brief No. 705.

This article is a background briefing on the need for cultural competence. It outlines the different roles assumed by the federal government, such as data collection, service provision, and rules for contracting organizations, and those assumed by states, including legislation that addresses cultural competence, mostly focused on interpreter requirements. Finally, the article highlights some innovative programs that seek to develop cultural competence, including one to develop a systems approach to assessing cultural competence in health care organizations. Other programs highlighted included the following elements: interpreters, telephone triage in multiple languages, translated written materials (e.g., disclosure forms and patient education), audio-visual presentations in a range of languages, traditional healing, diversity training for staff, curricular guidelines for specialties, annual reviews of cultural competence, training physicians on the use of interpreter services, multidisciplinary outreach teams, and conducting focus groups to collect data from various ethnic groups.

Meleis AI (1996). Culturally competent scholarship: Substance and rigor. **Advances in Nursing Science**, 19(2), 1-16.

The author addresses the need for cultural competent scholarship in nursing, as one aspect of viewing the patient. The authors warns that "culture is only one component of what defines a human being; defining nursing clients as cultural beings may be as reductionist as defining them as biological or physiological beings. The article presents eight proposed criteria for ensuring rigor and credibility of culturally competent scholarship that can be used as guidelines for the research process and as criteria to evaluate programming. The eight criteria are: contextually, communication styles, awareness of identity, power differentials, disclosure, reciprocation, empowerment, and time.

Pasick RJ, D'Onofrio CN, Otero-Sabogal R (1996). Similarities and differences across cultures: questions to inform a third generation of health promotion research. **Health Education Quarterly,** 23, 142-161.

This article looks at what role culture should play in health promotion and designing interventions, specifically presenting a framework to assess cultural needs of ethnic groups. The authors identified the following similar areas of focus in several different cancer screening programs: medical care settings, location of community activities, peer education and testimonials, message content, frontline professionals of similar cultural backgrounds to whom patients could relate to, and style and language of print material.

Pernell-Arnold A (1998). Multiculturalism: Myths and miracles. **Psychiatric Rehabilitation Journal**, 21(3), 224-229.

The shift of the melting pot paradigm to multiculturalism is explored. The melting pot myth relates to the fact that many groups were not permitted to assimilate. A foundation is built for the connection between psychosocial rehabilitation (PSR)

and multicultural approaches. PSR interventions are to be modified to respond to differences in cultural belief systems, help-seeking behaviors, and symptom development. Recommendations are made on issues and strategies that PSR programs can utilize when starting the process of becoming culturally, competent.

Philips D, Leff S, Kaniasty E, Carter M, Paret M, Conley T, Sharma M (1999). **Culture, race, and ethnicity in performance measurement: A compendium of resources, version 1.** The Evaluation Center at HSRI and the Center for Mental Health Services. Prepared for the Substance Abuse and Mental Health Services Administration, Depatment of Health and Human Services. Washington, DC.

This is an expansive reference on articles and definitions from multiple government agencies concerning cultural competence. It describes an approach to developing and assessing the cultural competence of the service system that evolved during the Evaluation Center at HSRI work with the NACBHD Outcomes Committee. The compendium is a compilation of resources and readings for those interested in the area of providing or evaluating culturally competent mental health care.

Puebla-Fortier J, Shaw-Taylor Y (1999). **Cultural and linguistic competence standards and research agenda project.** Resources for Cross Cultural Health Care. Prepared for the Center for the Advancement of Health, and the Office of Minority Health, Department of Health and Human Services. Washington, DC.

This article represents an effort by the Office of Minority Health at the Department of Health and Human Services to develop standards for culturally and linguistically appropriate services (CLAS). The article discusses the numerous difficulties in researching CLAS and its relationship to outcomes. The fourteen CLAS standards can be grouped into five categories: culturally sensitive encounters, choice of providers, language services, translated materials, and input into treatment decisions and service quality. The authors present research questions that relate the development of structure, process, and outcome measures for each of the five categories of standards. They also suggest possibly linking CLAS-related indicators to Medicaid risk adjustment, managed care reimbursement policies, and utilization related issues as possible ways to increase demand for CLAS-related research.

Rubenstein HL, O'Connor BB, Nieman LZ, Gracely EJ (1991). Introducing students to the role of folk and popular belief systems in patient care. **Academic Medicine**, 67(9), 566-568.

This article presents the results of an exercise carried out by the faculty at The Medical College of Pennsylvania to improve their medical students' ability to recognize and work effectively with the health beliefs and practices of their patients. The faculty feels that physicians need to understand the pervasiveness of the nontraditional beliefs and practices of their patients and actively elicit beliefs from their patients in order to provide the best care possible. The authors instituted a four-hour session for sophomore medical students that introduced guidelines for eliciting and working with patients' nonconventional health beliefs and practices. A pre- and post-test were administered to test the students before-and-after knowledge of (1) the ways in which a physician's ignorance of a

patient's health beliefs and practices can adversely affect the clinical encounter; (2) the pervasiveness of nonconventional health beliefs and practices; and (3) the types of resources available for learning about these beliefs and practices. Students' knowledge and awareness improved significantly between the pre- and post-test.

Salimbene S (1999). Cultural competence: a priority for performance improvement action. **Journal of Nursing Care Quality,** 13(3), 23-35.

This article outlines a model for developing cultural competence among nurses using a "cultural filter theory" of perception whereby every individual perceives the world around him or her through a filter that is created and adopted by all members of a culture. This filter determines what is said and how things are said and includes facial expressions, body language, gestures, behavior, and speech. The cultural filter is also responsible for how a person interprets his or her illness and the cause of illness. The author outlines the skills and abilities that constitute culturally competent nursing care. The stages in this model include: ethnocentricity or seeing one's own culture as the standard measurement, the awareness and sensitivity to cultural and language differences, the ability to refrain from forming stereotypes and judgments that are based on one's own cultural framework, the acquisition of knowledge about the cultures of patients the organization serves, and the acquisition of new skills and strategies to identify cultural differences and to know how to deal with them in a way that meets patients needs and the standards of quality care.

Smith LS (1998). Cultural competence for nurses: canonical correlation of two culture scales. **Journal of Cultural Diversity**, 5(4), 120-126.

This study measures the relationship among scores and sub-scores on scales measuring cultural competence among a population of registered nurses. The scales used are the Giger and Davidhizar Transcultural Assessment Model and Theory, the Cultural Self-Efficacy Scale (CSES), Cultural Attitude Scale (CAS – Modified), in addition to a knowledge base questionnaire.

Texas Department of Health. (1997) **Pursuing organizational and individual cultural competency: An epistemology of the journey towards cultural competency.** Prepared for the Maternal and Child Health Bureau, Health Resources Services Administration, U.S. Department of Health and Human Services.

This article explores the limits, validity, grounds, principles and standards for cultural competence. The publication explores the distinction between cultural diversity and cultural competence, as well as the myths and misconceptions related to cultural differences, which are given credence and validity. For example the authors point out the weakness of training curriculums that teach diversity as recognition of differences. A manual provides tools for defining training objectives, assessing the training environment and assessment of training methods and outcomes. The authors argue that from individual expansion comes organizational impact, which can only be measured with proper training standards and means of evaluating the impact.

Weiss CI, Minsky S (1994). **Program self-assessment survey for cultural competence: manual.** Prepared for the New Jersey Division of Mental Health and Hospitals.

This survey was developed by the Multicultural Services Advisory Committee to assist mental health programs in delivering culturally competent care. The survey is not aimed at assessing staff's level of cultural competency, but rather an organization's ability to address the needs of culturally diverse groups. The survey assesses an organization's level of cultural competency by reviewing program policies and practices. Survey questions address organizational practices related to client diagnosis and assessment, physical characteristics of the facility, staff recruitment, and client participation. The scores are tallied to create a program profile.

Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch HG (1995). Language barriers in medicine in the United States. **JAMA,** 273(9), 724-728.

This article reviews the current status of interpreter services in the United States health care system, the clinical impact of inadequate interpretation and the legislative responses to the language needs of patients with limited English proficiency. Patients and clinicians tend to rely on one of three sub-optimal mechanisms for interpretations: (1) their own language skills, (2) the skills of family or friends, or (3) ad hoc interpreters. The DHHS Office for Civil Rights views inadequate interpretation as a form of discrimination. Language barriers impair the exchange of information from patient to physician in several ways leading to misdiagnosis and non-education. Inadequate interpretation also raises ethical problems related to informed consent. The authors offer a number of simple low cost interventions to improve access to bilingual services including: (1) multilingual signs and videos to inform patients about interpreter services; (2) bilingual phrase sheets for staff and patients; and (3) telephone interpreter access.

Performance Measures and/ or Indicators

Abt Associates (2000). **Report on recommendations for measures of cultural competence for the quality improvement system for managed care.** Prepared for the Health Care and Financing Administration. Washington, DC.

This report includes a set of recommendations for measures of cultural competence of managed care organizations that provide care to Medicare and Medicaid beneficiaries under contracts with HCFA or with State Medicaid agencies. The measures were developed for use in the Quality Improvement System for Managed Care (QISMC), which is a system designed to ensure that organizations providing health care services under contract protect and improve the health and satisfaction of enrolled beneficiaries. Recommendations for measures were developed from input from experts in the field of cultural competence. The Expert Panel recommended that HCFA develop measures of the following three types: 1) disparity-based measures; 2) enrollee-based measures; and 3) standards-based inventories of current practices. Disparity-based measures would identify disparities in access to care and disparity in preventive care, such as flu shots. Enrollee-based measures would assess the beneficiaries' ability to choose congruent providers and language services. Standard-based measures

would assess whether MCO had a process for identifying and addressing disparities.

The Bureau of Primary Health Care. (1999). **Cultural Competence: A Journey.** Health Resources and Services Administration, Bureau of Primary Health Care.

This publication summarizes the experiences of community programs affiliated with the Health Resources and Services Administration's Bureau of Primary Health Care that provide services to culturally diverse populations. This document profiles a variety of programs such as the Sunset Park Family Health Center in New York and the Red Tail Training and Health Center in Minneapolis and chronicles their experiences in providing culturally competent service delivery, such as incorporating traditional healing, creating health facilities that are more welcoming and attractive to patients through signage and interpreters, and training culturally sensitive clinicians. The document also outlines 5 essential elements that contribute to a system's ability to become more culturally competent, 7 domains of cultural competence and describes public health studies that demonstrate improved health outcomes resulting from providers' ability to bridge cultural gaps between themselves and their patients.

Center for Mental Health Services (1998). **Cultural competence standards in managed mental health care: Four underserved/underrepresented racial/ethnic groups.** Prepared for the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Purchase Order No. 97M047622401D.

This report addresses the need to ensure the provision of culturally competent services to underserved and underrepresented racial/ethnic groups in managed care settings. The report provides tools to guide the provision of culturally competent mental health services to four racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans and Asian/Pacific Islanders. Input was gathered from expert panels of consumers, mental health services providers and academic clinicians representing each of the four racial/ethnic populations. Each panel reviewed mental health research and services literature that focused on their respective population and developed a consensus around how best to achieve culturally competent managed behavioral health care for its target population. Two types of standards were developed: overall system guidelines, and clinical standards and implementation guidelines. Overall system guidelines focused on ensuring a culturally competent system of care and included standards on cultural competence planning, governance, benefit design, outreach, quality improvement, information systems, and human resource development. Clinical standards and implementation guidelines focused on ensuring culturally competence clinical practices and included: discharge planning, treatment services, and communication styles. For each standard, the report included a list of recommended performance indicators and outcomes.

Flores G (1999). **A model of cultural competency in health care.** Progress Notes: A Newsletter of the Massachusetts Chronic Disease Improvement Network. The Massachusetts Chronic Disease Improvement Network, 3(1), 1-3.

This article includes a model of cultural competency and tools for use by providers to become knowledgeable about the role of culture in the patient-

provider interaction. The model includes 5 components; (1) "normative cultural values", which focuses on a clinician becoming familiarized with the values within a patient's culture; (2) "language issues", which focuses on the use of interpreter services and promotion of bilingual skills among clinicians; (3) "folk illnesses and remedies", which outlines a four step method for acquiring information from patients on their traditional treatment practices; (4) "patient/parent beliefs", which instructs clinicians on identifying beliefs that impact care and approaches for communicating to patients alternatives to traditional practices; (5) "provider practices", which focuses on tracking ethnically based disparities in screening, prescriptions and health outcomes.

Goode TD (1989. Revised 1993, 1996, 1999 and 2000) **Promoting cultural and linguistic competency. self-assessment checklist for personnel providing services and support to children with special health needs and their families.** Georgetown University Child Development Center- National Center for Cultural Competence (NCCC). Washington, DC.

This publication includes self-assessment tools developed by Georgetown University Child Development Center's National Center for Cultural Competence to be used by personnel providing primary health care services. Self-assessment tools were developed for a variety of topic areas, including "values and attitudes", "communication styles", and the "physical environment." Personnel are provided with a checklist that assesses how well they are demonstrating or engaging in practices that promote culturally diverse and competent services.

Cohen E, Goode TD (1999). **Policy Brief 1: Rationale for cultural competence in health care**. Georgetown University Child Development Center- National Center for Cultural Competence (NCCC). Washington, DC.

Goode TD, Sockalingam S, Brown M & Jones W (2000). **Policy Brief 2: Linguistic competence in primary health care delivery systems: implications for policy makers.** Georgetown University Child Development Center- National Center for Cultural Competence (NCCC). Washington, DC.

These policy briefs are produced by Georgetown University Child Development Center's National Center for Cultural Competence. Policy Brief 1 and 2 include a checklist for organizations to assess how well they facilitate the development of culturally and linguistically competent primary health care policies and structures. This checklist includes items related to the incorporation of cultural competence principles into mission statements and policies regarding staff training, professional development and evaluation, and the allocation of dedicated resources to cultural competence activities.

Health Resources and Services Administration (2000). **Cultural Competence Works. Awards of Excellence.** "Certificates of Recognition Nominated Programs of Note" and "Certificate of Recognition." U.S. Department of Health and Human Services. Washington, DC.

This booklet includes an abstract of the "Cultural Competence Works Awards of Excellence" presented to various health care programs. One abstract included a description of the SouthCove Community Health Center in Boston, Massachusetts (SCCHC). The abstract outlined activities conducted by the Center to ensure

cultural competence, including performing client assessment and care planning in the client's primary language, recruitment of a bilingual staff, provision of interpreter training for medical staff, and the delivery of intensive, bilingual/bicultural outreach and community health education. Other programs profiled included the South Park Family Health Center Network, which conducts yearly community needs assessment, provides new staff orientation training in cultural diversity, uses Americorp members to delivery outreach and educational activities, and has a Cultural Access Task Force focused on developing and implementing culturally competent policies. The awards were presented by the Office of Minority Health, Maternal and Child Health Bureau, and Center for Managed Care at a January 10, 2000 ceremony.

Lavizzo-Mourey R, Mackenzie ER (1996). Cultural competence: essential measurements of quality for managed care organizations. **Annals of Internal Medicine**, 124, 919-921.

This article addresses the need to establish guidelines of cultural competence for managed care organizations. In this article, cultural competence is defined as the demonstrated awareness and integration of the following three components: (1) "health-related beliefs and cultural values", which incorporates the belief system and perspectives of cultural subpopulations; (2) "disease incidence and prevalence", which requires that MCOs take into account the varying disease incidence among racial and ethnic subpopulations and collect accurate epidemiologic data to guide decisions about health education, screening and treatment programs; and (3) "treatment efficacy", which focuses on the population-specific pharmacologic efficacy of treatment across different populations. The article provides various illustrations of these three components in managed care organizations.

Mason JL (1995). **Cultural competence self-assessment questionnaire: A manual for users.** Portland State University, Research and Training Center on Family Support and Children's Mental Health. Washington State.

This report includes an instrument to access cultural competence in agencies serving children and families. The instrument includes a version for service providers and for administrative personnel. Questions included in the instrument provide ways to evaluate understanding and application of cultural competence concepts by staff. This tool is applicable across a wide range of settings.

Maternal and Child Health Bureau (2000). **Maternal and child health services Title V block grant program: guidance and forms for the Title V application/annual report**. U.S. Department of Health and Human Services. Washington, DC.

This document contains instructions for Title V Maternal and Child Health Block Grant grantees for submitting application and annual reports. Contained within this document are performance measures on which grantees are required to report. Specific measures related to cultural competence include health outcome measures and developmental health status indicator measures.

Maternal and Child Health Bureau (1990). **State children with special health care needs Title V directory workshop: Improving state services for culturally diverse populations.** Prepared for Division of Services for Children with Special Healthcare

Needs, Maternal and Child Health Bureau, Health Resources and Service Administration, and Department of Health and Human Services. Washington, DC.

This report summarizes proceedings from a Work Group convened during a May, 1990 conference entitled "Cultural Perspectives in Service Delivery for Children and Families with Special Needs." The conference was convened by the Maternal and Child Health Bureau to assist states in assessing and improving delivery of services to culturally diverse populations of children with special needs and their families. The Work Group developed specific guidelines, strategies, policies and activities that could be undertaken by states to accomplish the goal of culturally competent health care delivery. The Work Group identified critical components of culturally competent programs and outlined a set of objectives to assist States in achieving these components.

Munoz RH, Sanchez AM. **Developing culturally competent systems of care for state mental health services.** Prepared for Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Washington, DC.

This report examines the impact of culture on mental health, strategies for instituting cultural competency into mental health care, and a plan of action for developing a culturally competent system of care. The report provides a framework of a culturally competent system of care and outlines essential components of that system. Also included is the experience of five states that apply culturally competent principles in real-life settings. States recount challenges and difficulties in implementing these principles. This report also includes an appendix of assessment tools. Those tools include patient satisfaction surveys, and provider and organization self-assessment of cultural competency.

Nelkin VS (1994). **Implementing the surgeon general's action agenda: To improve access to care and quality of life for all children with special healthcare needs and their families.** Prepared for Division of Services for Children with Special Health Care Needs, Maternal and Child Health Bureau, Health Resources and Service Administration, and Department of Health and Human Services. Washington, DC.

This report describes results of a survey conducted in 1992-1993 of Special Projects of Regional and National Significance (SPRANS) and Maternal and Child Health Improvement Project (MCHIP) grantees. The survey assessed grantees' progress in achieving action steps outlined by the Surgeon General. One of these action steps related to culturally competent care. Assessment of progress was measured along a scale ranging from "no action taken" to "activity has become standard practice in other settings." In terms of culturally competent care, grantees were assessed on whether they implemented culturally competent care concepts and activities, such as translated materials, incorporation of cultural values in services delivery and planning, inclusion of culturally diverse families on advisory groups, recruitment and hiring of culturally diverse staff, and training of staff on cultural competence principles. Specific indicators for each of these activities were also identified.

New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (1998). **Cultural competence performance measures for managed behavioral healthcare programs.** In Collaboration with the Center for the Study of Issues in Public Mental Health. Prepared for the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Department of Health and Human Services. Washington, DC.

This report was undertaken to address whether services delivered by mental health organizations reflected and responded to the needs of culturally and ethnically diverse populations. Input from a steering committee, an expert panel, and focus groups was used to develop a conceptual framework of cultural competence and a set of performance measures aimed at assessing how well managed care organizations and other mental health programs are providing services to multicultural groups. The conceptual framework of cultural competence was developed using 6 domains of mental health service delivery: 1) needs assessment; 2) information exchange; 3) services; 4) human resources; 5) plan and policies; and 6) outcomes. Performance measures were selected for each of these domains based on: a review of standards of cultural competence developed by Federal and State entities and managed care organizations; a review of literature focused on mental health systems and cultural competence; and interviews with experts in the field of cultural competence and consumers and providers of mental health care services. Performance measures were applied to three levels: 1) administrative level; 2) provider network level; 3) and the individual provider level and data sources were identified. The report concludes with a set of recommendations for selecting the most appropriate performance measures and a plan for implementing these measures within the internal policies and planning of an organization.

Office of Minority Health (1999). **Assuring cultural competence in health care: Recommendations for national standards and outcomes-focused research agenda.** Recommended Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care Services. Prepared for the U.S. Department of Health and Human Services. Washington, DC.

This report responds to the need to develop consensus and standards regarding what constitutes cultural or linguistic competence in health care service delivery. This report outlines a set of 14 standards for use by various stakeholders, including providers, policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators and the health care community in general. The expectation is that the standards will provide guidance to providers on how to provide culturally competent care and provide policymakers and consumers with the tools to evaluate and assess whether a provider is delivering culturally competent care. The recommended standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. The process used in developing the standards included the formulation of research questions and a review of technical and policy literature to identify categories of cultural competence. A content analysis of the literature was conducted which identified two thematic clusters corresponding to (1) linguistic competence (i.e., language access, interpreter and translation services)

and (2) cultural competence (i.e., patient, staff and organizational cultural diversity management). An initial list of 21 draft standards was consolidated to 14 standards. The standards relate to a variety of areas, including policies and organizational structures, consumer involvement, training and education of staff, and the provision of interpretation services. Along with recommended national standards, the report also outlines a research agenda for relating the standards to outcomes.

Texas Department of Health. **Journey towards cultural competency: Lessons learned.** National Maternal and Child Health Resource Center on Cultural Competency. Prepared for the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. Washington, DC.

This report outlines a process for achieving cultural competency and describes lessons learned from this process. The National Resource Center on Cultural Competence outlined 10 steps for achieving cultural competency: 1) gathering demographic information on clients and information from staff on knowledge, attitudes, and skills related to cultural competence; 2) achieving top management support to implement cultural competence; 3) establishing a work group/task force to place a plan into action; 4) conducting an organizational assessment to indicate capacity and need; 5) developing a long range plan based on the assessment evaluation; 6) conducting of cultural competency training of staff and providers; 7) coordinating with collaborators in the public and private sector; 8) implementing long range plans at the individual, policy, administrative, and service provision levels; 9) using consultants to assist in cultural competency assessment; and 10) disseminating information and experiences to stakeholders.

Tirado M (1996). **Tools for monitoring cultural competence in health care.** Prepared by the Latino Coalition for a Health California. San Francisco, CA.

This report was prepared for the Office of Planning and Evaluation at the Health Resources and Services Administration. The report includes tools to monitor providers' cultural competence. Expert panels comprised of primary care physicians and other health care professionals were convened to assist in the development of these provider cultural competence tools. The Expert Panel focused on developing tools targeted at three chronic conditions: asthma, diabetes, and hypertension. Other input was gathered from individual panel member interviews and focus groups conducted with patients. A provider self-assessment and a patient satisfaction survey was developed and included indicators of cultural competence in managed care and other settings.

Program- and Condition-Specific Studies

General and Consumer Satisfaction

Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. (1996). Use and effectiveness of interpreters in an emergency department. **JAMA**, 275(10), 783-788.

This article assesses the use of interpreters in the emergency departments, examining when their use is appropriate and what impact their use has on consumers' understanding of their diagnosis and treatment, and their satisfaction

with care. Variables examined included interpreter use, necessity of interpreter, providers' ability to speak Spanish, and consumers' ability to speak English. One issue that the authors raise is the high prevalence of illiteracy in limited English proficient patients and the need to consider this when deciding whether or not to employ an interpreter. Interpreter use varied by both patients' and examiners' self-reported language proficiency and decreases in language proficiency corresponded with increases in interpreter use. Patients' understanding of discharge directions and diagnosis was less when interpreters were not used.

Barton JA, Brown NJ (1992). Evaluation study of a transcultural discovery learning model. **Public Health Nursing,** 9(4), 234-241.

This qualitative, descriptive study explores the extent to which student's discovery learning, centered around cultural understanding and sensitivity occurs in clinic rotations. The study specifically looked at 13 students working with migrant health communities. The findings confirmed that students who participated built a deepening respect for a cultural minority group, honed skills to identify differences in cultural norms, and recognized the rewards gained in their transcultural experience.

Blackhall LJ, Murphy S, Frank G, Michel V, Azen S (1995). Ethnicity and attitudes toward patient autonomy. **JAMA**, 274(10), 820-825.

This article summarizes a study that examines the differences in the attitudes of elderly subjects from different ethnic groups toward disclosure of the diagnosis and prognosis of a terminal illness and toward end-of-life decision-making. The study examines the principle of patient autonomy that asserts that the patients have certain rights to make decisions about their medical care. The study used the Ethnicity and Attitudes Toward Advanced Care Directives Questionnaire and interviewed 200 individuals. The study showed that Korean- and African-Americans were significantly less likely that European- and Mexican-Americans to believe that a patient should be told the diagnosis of metastatic cancer or a terminal prognosis and less likely to believe that patients should make decisions about the use of life-support technology. Mexican- and Korean-Americans instead rely on their families to make these decisions. The authors discuss a "family-centered" model whereby it is the sole responsibility of the family to hear bad news about the patient's prognosis and diagnosis and make difficult decisions regarding life-support.

Braithwaite RL, Lythcott N (1989). Community empowerment as a strategy for health promotion for black and other minority populations. **JAMA,** 261(2), 282-283.

This article highlights the need for community empowerment and cultural competence in improving health outcomes for minority communities. The authors define community empowerment as a process of increased control by groups over consequences that are important to their members. They state that focused prevention efforts should emerge from a knowledge of and respect for the culture of the target community.

Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu Hong TP, Neil R., Nelson CF, Daniel E (1999). Race, gender, and partnership in the patient-physician relationship. **JAMA**, 282(6), 583.

The researchers conducted a telephone survey of 1816 adults age 18 to 65 with the objective of describing how the race and ethnicity, and the gender of patients and physicians are associated with physicians' participatory decision making styles. The data suggested that African Americans rate their visits with physicians as less participatory than whites thus demonstrating a need for improved cross cultural communication.

Dana RH (1998). Projective assessment of Latinos in the United States: current realities, problems and prospects. **Cultural Diversity and Mental Health**, 4(3), 165-184.

This article examines biases in assessment and professional mental health practice with Latino populations and suggests a measure for assessment, followed by several descriptive tests and suggestions for reduction of cultural based bias through guidelines. The author critiques the major projective methods used by psychologist with Latino populations and suggests guidelines for nine major areas to promote competent assessment practice with Latinos. The nine areas are: population diversity, language, service delivery style, acculturation, interpretation, psycho-diagnosis, personality theory, and shared personality findings.

Delgado JL, Johnson CL, Roy I, Trevino FM (1990). Hispanic health and nutrition survey: methodological considerations. **American Journal of Public Health**, 80 Suppl, 6-10.

This article focuses on the methodological considerations of HHANES (Hispanic Health and Nutrition Education Survey) and the difficulties of assessing particular topics related to ethnicity, such as acculturation. HHANES studied chronic conditions and some behavioral issues, including nutrition. HHANES uses five data collection techniques: direct physical exams, diagnostic testing, anthropometry, lab analysis, and interview. Virtually all interview staff were bilingual and bicultural.

Denboba DL, Bragdon JL, Goldman T (1998). Reducing health disparities through cultural competency. **Journal of Health Education,** 29(5), S47.

This article focuses on how HRSA has defined and integrated cultural competence in the programs it funds and provides an overview of HRSA's programs in cultural competence, and lessons learned from the HRSA programs. The article identifies potential resources or partners in the delivery of culturally competent health care within HRSA programs. Additionally, it suggests strategies in operationalize culturally competent policies and practices through lessons learned by other's experiences. The article suggests that HRSA's role in the area of cultural competence has been and will continue to be providing leadership, guidance, and opportunities for collaborating in training, development of community and consumer partnerships, developing model strategies, and research.

Dressler SW, Viteri FE, Chavez A, Grell GA, Dos Santos JE (1991). Comparative research in social epidemiology: measurement issues. **Ethnicity and Disease**, 1(4), 379-393.

This article summarizes a complex epidemiological methodology that derives and evaluates cross-culturally valid measures of behavioral and sociocultural factors that may lead to an increase in blood pressure or the risk of disease. The author

suggests that not all variance in blood pressure can be explained by the traditional risk factors for hypertension (i.e. diet, heredity, exercise, etc.). Instead social and cultural factors also have an impact. It is, however, difficult to measure these social and cultural factors in a way that is comparable across cultures. The purpose of this study is to develop a set of variables that measure the effects of social and cultural factors on blood pressure that are equivalent across cultures (measurement equivalence).

Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL (1993). Unconventional medicine in the United States: prevalence, costs, and patterns of use. **New England Journal of Medicine**, 328(4), 246-252.

This paper presents the results of a study undertaken to estimate the prevalence, use, cost, and reasons for use of "unconventional medicine" in the United States,and providers' awareness of it. Unconventional therapies are defined as medical interventions not widely taught at U.S. medical schools or generally available at U.S. hospitals. A representative sample of 1539 households was contacted and interviewed using a phone survey. The results from these interviews were extrapolated to the U.S. population. The results showed that one in three respondents used at least one unconventional therapy in 1990 and that relaxation techniques, chiropractic, and massage were the therapies used most often. Almost 9 out of 10 respondents saw an unconventional provider without the recommendation of their medical provider and most respondents paid the entire cost of their visit out of pocket.

Gant LM (1996). Are culturally sophisticated agencies better workplaces for social work staff and administrators? **Social Work**, 41(2), 163-71.

This article examines staff perceptions of an agency as a culturally sophisticated organization that promotes policies and practices that are either barriers to or facilitators of appropriate services for culturally diverse clients. Cultural sophistication is used by the author to outline three themes: knowledge and information about cultures, how people feel about cultures, and how to effectively interact with staff and clients of other cultures.

Health Resources Services Administration (1999). **HRSA fact sheet: Assuring access to health care.** Department of Health and Human Services. Washington, DC.

This article describes HRSA efforts to assure access to health care, specifically discussing access in underserved communities, access for populations with HIV/AIDS, access for women and children, access to better trained professionals, and access to quality and equality of care. HRSA's programs to improve access to better trained professionals targets increasing diversity, including racial and ethnic diversity, in the workforce by providing training opportunities and support.

Hennessy LL, Friesen MA. (1994). Perceptions of quality of care in a minority population: A pilot study. **Journal of Nursing Care Quality**, 8(2), 32-37.

This paper presents the results of a study done to assess Mexican-American patients' perceptions of quality of care delivered by health care providers in two hospitals. This study used the "Patient Judgment System" to assess patients' perception. Results showed that Mexican-Americans were more concerned with the environment and "caring" with which care was delivered rather than the

technical or skill levels of care provided. In addition, it was evident that those subjects in the lower socioeconomic groups were generally less satisfied with the care they received.

Kington RS, Smith JP (1997). Socioeconomic status and racial and ethnic differences in function status associated with chronic disease. **American Journal of Public Health,** 87(5), 805-810.

This article discusses the relationship between socioeconomic status and racial and ethnic differences in the prevalence of diabetes, heart conditions, hypertension, and arthritis. The study shows that socioeconomic status plays a greater role in explaining racial and ethnic differences in an individuals' ability to function once someone is ill, rather than explaining the differences in the probability of becoming ill.

Ludwig-Beymer P, Blankemeire JR, Casas-Byots C, Suarez-Balcazar Y (1996). Community Assessment in a Suburban Hispanic Community: A Description of Method. **Journal of Human Lactation**, 12(2), 117-122.

This article addresses the methods used to learn about the Hispanic community in Des Plaines, Illinois. The researchers based their methods on Leininger's theory of culturally competent care. Steps included conducting three focus groups, constructing a structured interview guide, collecting data, analyzing data and then reporting the findings back to the Hispanic community. As a result of the analysis the Genesis Health and Empowerment Program was developed.

Massachusetts Chronic Disease Improvement Network (1999). **Progress notes: A newsletter of the Massachusetts chronic disease improvement network.** 3(3).

The newsletter contains two articles. One looks at practicing culturally sensitive health care through the example of using folk remedies in conjunction with biomedical remedies. The article focuses on the importance of gathering a full patient history suggesting that if the doctor only gathers the information needed for a biomedical diagnosis and treatment plan, they will miss the nuances of the patient's story. This can lead to an unsuccessful encounter. The second article suggests a model for ascertaining the cultural attributes of each patient, and responding appropriately to the cultural values, language issues, folk remedies, patient beliefs, and ethnic disparities in health and use of services.

Moy E, Bartman BA (1996). Physician race and care of medically indigent patients. **JAMA,** 273(19), 1515-1520.

This article presents the results of a study that uses the 1987 National Medical Expenditure Survey to examine the relationship between physician's race and care provided to racial minority patients and medically indigent patients. The purpose of the study was to see if nonwhite physicians are more likely to provide care to racial and ethnic minorities, the medically indigent, and sicker patients. The results revealed that minority patients were more than four times more likely to receive care from nonwhite physicians, than non-Hispanic white patients. Low-income, Medicaid, and uninsured patients were also more likely to receive care from nonwhite physicians. Individuals who receive care from nonwhite physicians were more likely to report worse health. The authors raise several concerns with these results including that nonwhite physicians may be financially

penalized for caring for nonwhite populations and the need for enhanced instruction in multicultural diversity among physicians.

Perry CM, Shams M, DeLeon CC (1998). Voices from an Afghan community. **Journal of Cultural Diversity**, 5(4), 127-131.

This article applies two specific assessment tools to examine an Afghan community in northern California. The article suggests that a major role of the community health nurse should be advocating to ensure that the need of specific ethnic and racial communities are met. The article presents an example of how this assessment can be conducted.

Starfield B, Cassady C, Nanda J, Forrest CB, Berk R (1998). Consumer experiences and provider perceptions of the quality of primary care: implications for managed care. **Journal of Family Practice**, 46(3), 216-226.

This article summarizes a study focused on determining the extent to which consumer and provider reports of primary care differ according to particular characteristics of the primary care setting. A telephone survey was administered to a random sample of Washington, DC residents to determine their experiences with care provided to one of their children. The primary care physician of the respondent was also sent a survey. The results showed that both consumers and their providers in settings characterized by high degrees of limitation of physician autonomy or by capitation reported better first-contact and a greater range of services available that did consumers with low degrees of limitation. Consumers also reported better family-centeredness in these settings.

Todd KH, Samaroo N, Hoffman JR (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. **JAMA**, 269(12), 1537-1539.

This article summarizes the results of a study that determined whether Hispanic patients with fractures to the humerus, radius, ulna, femoral shaft, tibia, and fibula were less likely to receive emergency department (ED) analgesics (pain relief) than similar non-Hispanic white patients. The study looked at the UCLA Emergency Medicine Center ED records for a 2-year period and used all Hispanic and non-Hispanic white patients between 15 and 55 years of age. The study group consisted of approximately 139 patients – 31 were Hispanic and 108 non-Hispanic. Results showed that non-Hispanic whites were twice as likely to receive ED pain medication and Hispanics were more likely to receive low-dose, oral or nonnarcotic analgesics. After controlling for several variables including ethnicity, sex, language, and insurance status, Hispanic ethnicity was still the strongest predictor of no analgesic. The authors suggest several reasons for this difference including the presence of patient advocates who might influence physicians and the failure on the part of physicians to recognize pain in culturally different patients.

Warda MR (2000). Mexican Americans' perception of culturally competent care. **Western Journal of Nursing Residence**, 22(2), 203-24.

The purpose of this study was to identify the culturally competent concepts from the perspective of the Mexican American health services consumer. The researchers conducted focus group interviews with Mexican American registered nurses and Mexican American lay recipients regarding the indicators of culturally

competent care. The authors suggest that respect, caring, understanding, and patience in health care encounters are the core of culturally competent care.

Wright F, Cohen S, Caroselli C (1997). Diverse decisions: how culture affects ethical decision making. **Critical Care Nursing Clinic of North America**, 9(1), 63-74.

This article looks at the concerns faced by the critical care nurse, often the first one to identify an ethical concern, in assisting patients and families in making ethical health care decisions, specifically addressing end of life issues. The authors present a process through which the critical care nurse can address how to assists the patient and family in ethical decision making. The article addresses the behavioral manifestations of culture that influence the patient such as verbal communication, non verbal communication, space, family structure, time, and view of illness and health. Finally the authors briefly address the specific cultural considerations for African Americans, Latinos, Filipinos, Southeast Asians, Native Americans and Jewish Americans.

Various (1991). Hispanic health issue. **JAMA,** 265(2), 238-241.

This articles highlights some of the key issues in access to care for Hispanic populations, including disparities in health status and location and institutional factors such as farm work, air/water quality concerns in border communities, and the paucity of Hispanic health professionals.

Cancer

Burns R, McCarthy E., Freund K, Marwill S, Shwartz M, Ash A, Moskowitz M (1996). Black women receive less mammography even with similar use of primary care. **Annals of Internal Medicine**, 125(3), 173-182.

Using Medicare claims from ten states, this article examines differences in mammography use between elderly black and white women. The use of mammography seems to increase as primary care visits increase, but black women had lower use rates than white women across all levels of primary care. However, within race, mammography use by black women did not vary greatly. Research has demonstrated that physicians are more likely to encourage elderly white women to obtain mammograms than elderly black women, highlighting concerns around provider attitudes. Black women have also been shown to have less knowledgeable about mammography than white women, highlighting concerns about patient education.

Davis DT, Bustamante A, Brown CP, Wolde-Tsadik G, Savage EW, Cheng X, Howland L (1994). The urban church and cancer control: a source of social influence in minority communities. **Public Health Reports**, 109(4), 505-506.

This article examines how to create the conditions for church-based cancer control, citing securing pastoral commitment and selecting lay health leaders as two critical components in its demonstration. The demonstration targeted African-American and Latina women and involved 24 churches in Los Angeles that offered cervical cancer education and Pap Smears to women 21 years and older. By the end of the two year project, 52 percent of the churches initiated continuation cancer control activities. "Social influence models that use

indigenous sources of social support can exert a positive influence on the participation of minority women in cancer control."

Mohrmann CC, Coleman EA, Coon SK, Lord JE, Heard JK, Cantrell MJ, Burks EC (2000). An analysis of printed breast cancer information for African American women. **Journal of Cancer Education,** 15(1), 23-27.

The Delta project was designed to increase breast cancer screening among minority women by educating health care professionals, who serve these populations, about breast health. The research team did a review for appropriate educational materials, found none, and discussed the importance of recognizing that the culture of the patient influences the effectiveness of printed materials motivating compliance and changing attitudes and behaviors.

Perez-Stable E, Sabogal F, Otero-Sabogal R, Hiatt R, Mcphe S (1992). Misconceptions about cancer among Latinos and Anglos. **JAMA**, 268(22), 3219-3223.

This article summarizes findings of a survey comparing knowledge about and attitudes toward cancer among self-identified Latino or Anglo health plan members. The study showed that after adjusting for education, age, sex, county of residence, health status and employment, Latinos remained significantly more likely to have misconceptions about the causes of cancer and to have less knowledge about the symptoms of cancer. In addition, the study suggests that attitudes that may be detrimental to cancer control efforts were more prevalent in the Latino population. The fear of cancer as a "death sentence" and the perception that there is little a person can do to prevent cancer are themes found in the Latino population. The authors point out that the cultural concept of *fatalismo* (or fatalism) may lead some Latinos to assume that there is little a person can do to alter his or her fate in developing cancer, and thus may lead some to be less likely to change behavior that increases cancer risk. The authors suggest that new materials need to be developed in simple Spanish to provide accurate cancer information and address ethnic-specific issues and concerns.

White JE, Begg L, Fishman NW, Guthrie B, Fagan JK (1993). Increasing cervical cancer screening among minority elderly: education and on-site services to increase screening. **Journal of Gerontological Nursing,** 19(5), 28-34.

This articles summarizes findings of a study designed to determine the degree to which an intensive nursing intervention, consisting of education and onsite cervical cancer screening, could increase the rate of cervical cancer screening in elderly women. The authors point out that race is a predictor of the stage at which cervical cancer is diagnosed as elderly black and Hispanic women have lower rates of cervical cancer screening. The study found that educational interventions increase the awareness of the need for routine Pap testing among the elderly but leaves unanswered questions about the most effective and efficient approaches to such interventions.

Yancey AK, Waldlen L (1994). Stimulating cancer screening among Latinas and African American women. **Journal of Cancer Education**, 9(1), 46-52.

This article describes the development of a culturally sensitive, cost-effective documentary on cervical and breast cancer targeted to the Latino population. Recent studies demonstrated that video modalities are effective in increasing

knowledge and promoting health-protective behavior in low-income minority populations especially when they are designed to address the cultural beliefs of specific races/ethnicities. This study used a focus group of Latinas to develop an understanding of the attitudinal barriers related to cultural values to breast and cervical cancer screening. Two Spanish-language videotapes on cervical cancer prevention and one on breast cancer were produced that emphasized relevant cultural dynamics, varied production elements with entertainment value, including music, information comprehensible to people with little formal education, and a short, moving, minimally didactic presentation. The article also presents a case study of the experience of increased demand for cervical cancer screening that occurred as a direct result of one video screening. After showing the video to 27 Latina mothers, all 27 attendees requested Pap smears. Soon after, requests numbered 60 from women informed by "word-of-mouth" dissemination. The monthly mean number of Pap smears requested during the following few months was nearly twice that of previous years.

Yancey AK, Tanjasiri SP, Klein M, Tunder J (1995). Increased cancer screening behavior in women of color by culturally sensitive video exposure. **Preventive Medicine**, 24(2), 142-148.

This article presents the results of a formal evaluation of a culturally sensitive health education video intervention conducted in two community health clinic waiting rooms. The study was designed to test the hypothesis that exposure to culturally sensitive videos in waiting rooms can influence cervical cancer screening behavior. In addition, the value of the videotapes among differing Latino populations was explored by choosing intervention sites in different cities. Two community health clinics were chosen - one in the Upper West Side of Manhattan in New York City and the other in West Los Angeles. The videos were displayed in one or more clinic waiting rooms using a 1-week-on – 1-week-off study design. Follow up data was obtained from monthly laboratory summary reports. Results of the study show that the proportion of women who received Pap smears was approximately one-third higher among those who were exposed to the video intervention than among those in the control group at each clinic.

Diabetes

Luyas GT (1991). An explanatory model of diabetes. **Western Journal of Nursing Research**, 13(6), 681-697.

This study describes the explanatory model for Type II non-insulin dependent diabetes used by 19 low-income Mexican American women who have the disease. Explanatory models of specific diseases address how a person talks about disease and relates to illness as a response to culturally based life styles.

Oomen JS, Owen LJ (1999). Culture counts: why current treatment models fail Hispanic women with Type II diabetes. **Diabetes Education**, 25(2), 220-225.

The article looks at the barriers to care for Type II diabetes among Hispanic women. The authors suggest that established health behavior models do not adequately address the unique needs of the population and that there is a need for

interventions based on comprehensive, culturally sensitive models that work with cultural norms. The article suggests several culturally sensitive methods for increasing treatment adherence in female Hispanics with Type II diabetes, including, determining whether the patient is using any alternative forms of care, maintaining open communications with patient and family, asking direct questions on follow up visits about treatment adherence, barriers to compliance, and possible solutions.

Perez-Stable E, Napoles-Springer A, Miramontes J (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. **Medical Care,** 35(12), 1212-1219.

This study looks to fill the gap in research that has compared the well being functioning of patients from different ethnic backgrounds with chronic medical conditions. The study addresses the question of how cultural factors affect a patient's communication with their physician and as a result influence health outcomes. To address this question the study conducts a cross sectional study of 226 general medicine patients with hypertension or diabetes to compare the effect of ethnicity and language concordance with their physical health outcome measures, use of health care services, and clinical outcomes.

HIV/AIDS

DiClemente RJ, Wingwood GM (1995). A randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. **JAMA**, 274(16), 1271-1276.

This article tests the effect of educational sessions on HIV risk reduction with African American women aged 18-29 and represents the first randomized control trial of community-based HIV sexual risk reduction for economically disadvantaged young adult African American women. Two intervention groups were created, one that received five sessions of education and another that received the same educational material in one session. The material covered the following topics: gender and ethnic pride, knowledge of HIV and risk behavior, sexual assertiveness and communication training, proper condom use skills, and cognitive coping skills. The women who received the education in one session showed similar changes in behavior to those women who did not receive the intervention. However, the women who participated in the prolonged intervention were significantly more likely to have better cognitive skills, interpersonal skills, partner norms, and consistent condom use behavior than their counterparts. It was unclear how much of the prolonged intervention's success was based on African American women peer health educators and their credibility, communication, and ability to serve as positive role models.

O'Connor BB (1996). Promoting Cultural Competence in HIV/ AIDS Care**. Journal Association of Nurses of AIDS Care**, 7 Suppl 1, 41-53.

The article suggests some specific cultural competence training strategies and offers a broad conceptual framework for teaching and learning about the issues involved in cultural competence, with specific illustrations relating to HIV/AIDS.

According to the authors, gaining cultural competence is a developmental process that involves first, self-awareness and, second, a change of attitude by the group, peers, and staff concerning acceptance and flexibility. The article suggests that optimal, accurate and effective cultural assessment, must be carried out not just at the community or identity-group level but also on a case-by-case, person by person basis. Additionally the article addresses the constant need for providers, especially nurses, to negotiate between relationships and encounters and understand the paradox of respecting people's values and the customary behaviors that support those values while working to change them. The paper briefly concludes with a discussion of the process of creating cultural competence through workshops and training.

Goiceochea-Balbona AM (1997). Culturally specific health care model for ensuring health care use by rural, ethnically diverse families affected by HIV/AIDS. **Health and Social Work**, 22(3), 172-180.

The article presents the culturally specific health model (CSHCM), and illustrates how an interdisciplinary group formed to work in partnership with indigenous providers to respond to HIV crisis in a rural community. The author describes the process through which he developed the model and it's application to an outbreak of the AIDS epidemic in Belle Glade, Florida. The culturally specific health care model, which serves as a bridge between research and practice linking providers with consumers has four features: 1. a culturally specific description of the target community, 2. a culturally sensitive approach to assessment and intervention, 3. interdisciplinary collaboration among providers, and 4. the use of key indigenous providers. The model is suggested to guide health social workers in assessing and intervening with rural, ethnically diverse families.

Majumdar B, Roberts J (1998). AIDS awareness among women: the benefit of culturally sensitive education programs. **Health Care for Women International**, 19(2), 141-153.

This study evaluates the effectiveness of using culturally sensitive train-the-trainer type activities to increase knowledge and develop attitudes regarding AIDS in culturally diverse populations. The intervention involved training volunteer facilitators from different community groups, providing them with knowledge about HIV and skills to facilitate larger groups. Each facilitator then convened sessions through their organizations. Different facilitators used different facilitation techniques, varying by race and ethnicity. This resulted in exposing community participants to new information and changing attitudes towards those living with AIDS.

Mental Health/Substance Abuse

Amodeo M, Robb N (1998). Evaluating outcomes in substance abuse training program for Southeast Asian human service workers: problems in measuring change cross-culturally. **Journal of Drug Education**, 28(1), 53-63.

The article explores the challenges faced in cross cultural substance abuse training programs through the specifics of one course taught to Cambodian and Vietnamese human service workers over a two year period.

Bechtel GA, Davidhizar R, Tiller CM (1998). Patterns of mental health care among Mexican Americans. **Journal of Psychosocial Nursing and Mental Health Services**, 36(11), 20-27.

An analysis of mental health services to Mexican Americans using the Giger and Davidhizar model. The article suggests three improvements: (1) Extending cultural care beyond language enhances the use of mental health services and fosters a mutually agreed-on plan of care. (2) Understanding cultural characteristics facilitates an understanding of behavior, family and social dynamics, and adaptation patterns to stress that can empower clients to work toward their goals and validate the impact of emotions and behaviors on others. (3) Culturally appropriate mental health care reflects a synthesis among communication, space, social organization, time, environmental control, and biological variables.

Capers CF (1995). Mental health issues and African Americans. **Clinics in Geriatric Medicine**, 11(1), 1-13.

The article provides a brief overview of the issues of older African Americans, as a basis for discussion about specific concerns regarding diagnostic bias surrounding mental health issues. The conceptual model of Cultural Competence in Psychiatric Mental Health Nursing is used to organize the information presented, however, the model is also critiqued. Suggestions for the provision of culturally competent psychiatric care are provided.

Center for Mental Health Services (1996 June). **Managed care and ethnic minorities: Working group to develop an education agenda.** Prepared for Substance Abuse Mental Health Services Administration, Department of Health and Human Services. Washington, DC.

This article represents the efforts of a workgroup to develop an evaluation agenda to improve mental health and substance abuse service to African Americans, Asian/ Pacific Islanders, Latino, and Native Americas. The paper explores a set of values that promotes the success of ethnic minorities in order to maximize the benefits of managed care and suggests standards for broad evaluation areas. Working group members defined ten key areas for assessment: information systems, economics and finance, systems structure, human resources, clinical quality/ standards of care, service design, regulations, community norms, consumers/caregivers, and access. Furthermore, the group devised recommendations for continued efforts that support improvement of mental health services for ethnic minorities. These include: promoting collaboration among key stakeholders, encouraging follow-up insuring that the evaluation agenda developed is incorporated in ongoing discussions of managed care for people with mental illnesses at the federal, state, and local levels, adopting a market strategy through educating managed care organizations about the cost-effectiveness of providing appropriate mental health and substance abuse services to ethnic minorities, convening a regional or national conference, and continuing the dialogue to keep the needs of ethnic minorities in the forefront of the conversation about managed care.

Comas-Diaz L, Jacobsen FM (1995). The therapist of color and the white patient dyad: contradictions and recognition. **Cultural Diversity and Mental Health**, 1(2), 93-106.

The therapist of color and white patient dyad often involves contradictions and recognitions that are acknowledged through the specific processes and dynamics permeating this dyad. The relationship between self and other is frequently mediated through projection and identification. This article examines this unique interracial and interethnic therapeutic dyad emphasizing its clinical implications through the attribution of otherness, the use of colored screen projection, and the significance of power reversal.

Finley LY (1998). The cultural context: families coping with severe mental illness. **Psychiatric Rehabilitation Journal,** 21 (3), 230-240.

This article provides an overview of the unique needs of families from different ethnic and cultural backgrounds coping with a member with severe mental illness and of research on coping mastery among ethnic caregivers. Examples of alternative, and innovative culturally compatible approaches to enhance partnership, and support of families are described. Specifically, the article recommends that "family support" and the design of innovative support models occur within the context of the family's culture and are mediated by factors such as family background, ethnicity, ethnic identity, cultural affiliation, socioeconomic status and acculturation. The authors suggest there is a need for exploration of unique methods that explore the strengths of ethnic families and how culturally adaptive styles might be used effectively in working with different ethnic groups. The author addresses guidelines, approaches and different models for providing support to multicultural families.

Herrick CA, Brown HN (1998). Underutilization of mental health services by Asian-Americans residing in the United States. **Issues in Mental Health Nursing**, 19(3), 225-240.

The article examines the need for planning appropriate culturally competent mental health services for Asian-Americans, a group noted for less use of these services than other populations. A model for cultural competence can provide a framework for psychiatric nurses and other mental health professionals (MHPs) to become more aware of Asian-American values and beliefs and provide more culturally sensitive care. Awareness tools are included to guide MHPs in determining whether culturally competent care is available locally to meet the needs of this underserved population.

Malgady RG, Roglet LH, Costantino G (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: a program of treatment outcome research. **Journal of Consulting and Clinical Psychology**, 58(6), 704-12.

This article evaluates treatment outcomes of a program that attempts to introduce culture into therapy with Puerto Ricans that target anxiety symptoms, acting-out behavior, and self-concept problems. Evaluation of outcomes confirmed the impact of culturally sensitive modeling therapy on anxiety symptoms and other selected target behaviors, but negative treatment effects also were also evident. Results suggest that new approaches to psychotherapy for special populations, such as Hispanic children and adolescents, should be buttressed by programmatic research oriented toward the comparative evaluation of treatment outcomes and

should be attuned to therapeutic processes mediating between culture and outcome.

Morris TM (1990). Culturally sensitive family assessment: an evaluation of the family assessment device used with Hawaiian-American and Japanese-American families. **Family Process**, 29 (1),105-16.

This article reports the results of a study of the McMaster Family Assessment Device (FAD) used with samples drawn from two non-Anglo ethnic groups: Hawaiian-Americans and Japanese-Americans living in Hawaii. Results suggested that cultural norms regarding family functioning may vary according to socioeconomic status.

Western Interstate Commission for Higher Education (WICHE) Mental Health Program (1997 December). **Managed care and cultural competency in the delivery of mental health services.** Prepared for the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

The article summarizes the efforts of four National Racial/Ethnic Panels on Cultural Competence in Managed Care Health Services. Each panel developed ethnic-specific services, system and clinical standards, and provider competencies. The document also includes a strategic plan for implementing the cultural competence standards for delivery of services across the four racial/ ethnic groups, addressing specific initiatives that would facilitate successful implementation of standards. Additionally the WICHE Mental Health Program completed a survey of eleven Western states concerning changes in the public mental health system to identify a number of trends, including the response of managed care to service needs of racial/ ethnic populations.

Western Interstate Commission for Higher Education (WICHE) Mental Health Program, National Latino Behavioral Health Workgroup (1997 December). **Cultural competence guidelines in managed care Mental health services for Latino populations.** Prepared by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

The authors frame guiding principles and guidelines in response to opportunities for delivery of improved behavioral services to the Latino population under managed care. The report includes two sets of guidelines. One set of guidelines addresses non-clinical aspects of the health care delivery system, such as cultural competence planning, governance, benefit design, quality monitoring and improvement, decision support and management information systems, staff training and development, and provider competencies. The second set are clinical in nature focusing on access to care, triage and assessment, care planning, treatment services, case management and linguistic support. For each set of guidelines, the authors provide an objective, guidelines to meet the objective, recommended performance indicators and recommended outcomes.

Working Groups on Cultural Competence in Managed Mental Health Care (1997 October). **Cultural competence standards in managed mental health care for four underserved/underrepresented racial/ethnic groups, final report.** Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Washington, DC.

This article represents the culmination of separate and collaborative efforts of four national panels to develop cultural competence standards for mental health services for African Americans, Asian/Pacific Islanders, Latino/Hispanic, and Native American/American Indian/Native Alaskan/Native Hawaiian. The panels developed a set of principles underlying cultural competence, a definition of cultural competence, and standards for provider competencies. In terms of the health care system (e.g., health plans and public sector), they developed standards for planning, governance, benefit design, prevention/education/outreach, quality monitoring and improvement, decision support and management information systems, and human resource development. For clinical care, they developed standards for access and service authorization, triage and assessment, care planning, plan of treatment, treatment services, discharge planning, case management, communication styles and cross cultural linguistic and communication support, and self help. In terms of provider competencies, they assert that providers should have knowledge and understanding of consumer populations' backgrounds, clinical issues for different ethnic groups and sub-groups, how to provide appropriate treatment, agency and provider roles. They also assert the providers should have the knowledge and skills to communicate effectively across cultures, provide quality assessments, formulate and implement quality care and treatment plans, provide quality treatment, and demonstrate respectful attitudes.

Women's Health and Maternal and Child Health

Dickinson CP, Jackson DJ, Swartz WH (1994). Making the alternative the mainstream: Maintaining a family centered focus in a large freestanding birth center for low-income women. **Journal of Nurse Midwifery**, 39(2), 112-118.

This article analyzes the BirthPlace, a successfully "mainstreamed" alternative to maternity care program focused around the needs of the low-income Hispanic population in San Diego. The BirthPlace program primarily serves a public-funded, Hispanic population, with certified nurse-midwives as the primary providers. The BirthPlace program primarily serves a public-funded, Hispanic population, with certified nurse-midwives as the primary providers.

Doswell WM, Erlen JA (1998). Multicultural issues and ethical concepts in the delivery of nursing care interventions. **The Nursing Clinics of North America**, 33(2), 353-61.

This article uses a case study to describe a process that health care providers can use when faced with ethical dilemmas that arise when caring for patients from different cultures. Nursing strategies to promote culturally sensitive care are discussed, and include cultural assessment, heightening sensitivity to ethical issues in cultural diversity, and the role of continuing education in providing culturally competent care.

Maternal and Child Health Bureau (1991). **Improving services for culturally diverse populations; MCHB's division of services for children with special health needs activities, FY 1990-1991.** Bureau, Health Resources and Services Administration, Department of Health and Human Resources. Washington, DC.

This article reiterates MCHB's Division of CSHN's commitment to cultural competence and describes demonstration grants focused on specific groups and National MCH Center efforts. Activities grantees undertook to promote cultural competence can generally be grouped under outreach, identifying cultural barriers, providing cultural training, recruiting and hiring bilingual staff, including family in decisions, developing interstate coalitions, translating and using less medical and professional jargon

Im EO, Meleis AL, Lee KA (1999). Cultural competence of measurement scales of menopausal symptoms: use in research among Korean women. **International Journal of Nursing Studies**, 36(6), 455-463.

In this paper, cultural competence of the scales measuring menopausal symptoms were examined and critically analyzed for the limitation in research when applied to a population that the model was not developed for, Korean women. The study suggests that the validation of questions included in measurement scales though focus groups, explorations, and use of open ended questions, attention to language use, and knowledge of linguistic nuances need to be incorporated in pilot studies to enhance the development and use of culturally competent questions. Additionally pilot studies must look at the adequacy of terms, cultural stereotyping of responses, and its impact on symptom reporting, and appropriateness of communication styles need to be carefully examined.

Mattson S (1995). Culturally sensitive perinatal care for Southeast Asians. **Journal of Obstetric, Gynecologic, and Neonatal Nursing** , 24(4), 335-41.

The authors explore the specific considerations that need to be addressed when providing care to southeast Asians in the United States and Canada. The article looks at refugees' lifestyle and health problems, barriers to care, traditional healing practices, and the Southeast Asian Health Project, a program specifically designed to respond to the need for maternal and child care of a Southeast Asian community in the United States.

Naish J, Brown J, Denton B (1994). Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening. **British Medical Journal**, 309(6962), 1126-1128.

This paper presents the results of a study that examined the factors that deter ethnic minority women living in London from visiting their general practitioner for a Pap smear. The study used 11 focus groups, each with a total of six to ten women. Results showed that women reported that administrative and language barriers were more important than anxiety over the results of the test. The findings have several practice implications: (1) ethnic minority women are accepting of cervical cancer screening once the procedure is understood; (2) inadequate administration and language are potential barriers to screening; (3) concerns about surgery hygiene, sterility of equipment, and facilities for children deter women from treatment; and (4) focus groups using the patients' own

language were an effective way to consult with ethnic minority community groups.

Nelkin VS (1994). **Implementing the Surgeon General's action agenda: To improve access to care and quality of life for all children with special health needs and their families, survey of SPRANS/ MCHIP grantees.** Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services. Washington, DC.

This article represents the findings from a survey of SPRANS/MCHIP direct service grantees who work with children with special health care needs, including demonstration grantees and National MCH Centers. The report examines cultural competence and the Surgeon General's six action steps to improve access to care and quality of life for CSHCN: family-centered care, community-based care, provider preparation, coalition building, cost controls, adequate financing, and research and dissemination. Of the respondents, 93% were implementing family-centered care and community-based care, 80% were implementing provider preparation activities, 78% were implementing coalition building, 71% were implementing research and dissemination, 63% were implementing culturally competent care and cost controls, and 54% were implementing adequate financing. Indicators, and examples of how to make progress for those indicators, were provided for each of the action steps.

Pearce CW, Hawkins JW, Carver-Chase D, Ebacher R, Matta S, Sullivan A, Vawter VJ, Vincent C, Windle KA (1996). Comprehensive interdisciplinary care: making a difference in pregnancy outcomes for Hispanic women. **Public Health Nursing**, 13(6), 416-424.

This article reports on a cohort study that looks at the prenatal care received by 113 Hispanic women in a Northeast city. The outcomes of the study demonstrate a need for a model of care that is comprehensive, culturally sensitive, and encourages women's self care during pregnancy. The authors cite their study as evidence supporting the work of other researchers that recommend consideration of cultural variations in women's view of prenatal care when developing programs.

Randall-David E (1997 June). **Strategies for working with culturally diverse communities and clients.** Hemophilia Program, Maternal and Child Health Bureau, Department of Health and Human Services. Washington, DC.

This manual is designed as a workbook to help the health care provider increase their understanding of the cultural aspects of health and illness so that they can work effectively with individual clients and families from culturally diverse communities. It provides tools for providers to assess their own cultural heritage and to learn about the cultural values, beliefs and practices of the community they serve. The manual also provides guidelines for working with culturally diverse community groups and for using interpreters and other vehicles to enhance cross-cultural communication. Additionally there is a bibliography and various appendices that contain additional assessment tools and resources.

State CSHCN Title V Directory Workgroup (1990). **Improving state services for culturally diverse populations.** Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services. Washington, DC.

This article represents the work of a group of State Directors of CSHCN programs in 1990 to assess and improve service delivery for culturally diverse populations within their programs in the context of family-centered, community-based, culturally sensitive, coordinated care. The group developed recommendations to be implemented at the federal and state levels and defined critical components of culturally competent programs, such as collection of data on cultural groups in the state to identify their ethnicity, location, and gaps in services, family strengths, and needs, development of clear policy statements about cultural competence, committed outreach to identify children and families who need services, family and community involvement in developing and implementing policies and procedures, development of specific job descriptions for staff who work with children with special needs and their families of diverse cultural groups, training in cultural sensitivity and the concepts of culturally competent systems of care for agency staff and volunteers, coordination of services and case management at the community level that is appropriate for diverse populations, strong policies and clear procedures to protect clients, reorganization of systems to meet the needs of all children and their families, and interstate collaboration to promote continuity in family-centered, community-based, culturally competent, coordinated systems of care for children with special health care needs and their families.

Attachment 2:
Criteria for Literature Review

ATTACHMENT 2: CRITERIA FOR LITERATURE REVIEW

The set of criteria that follows consists of factors for consideration in judging the literature both in its theoretical and methodological rigor. The very nature of the field of cultural competence requires a set of criteria flexible enough to reflect the multiplicity of perspectives within the field, but also targeted enough to allow for a meaningful review.

- **Identification of definitions:** In developing a conceptual model of cultural competence, consensus must be achieved on the definition of cultural competence and its associated domains. Articles that present a cohesive and rational definition of the key constructs of cultural competence should be considered.
- **Identification of measures:** Phase II of the literature review involves identifying measures of cultural competence. Priority should be given to those articles that have developed a set of measures, standards, and/or guidelines that reflect a concrete manifestation of the abstract and theoretical construct of cultural competence.
- **Application in direct service settings:** Since the scope of this project is directed at developing measures of cultural competence for HRSA direct service delivery programs, articles that focus on direct service settings should be given priority. The importance of this criterion is that it suggests a real-world applicability of cultural competence in service delivery models.
- **Identification of tools used by direct service providers:** In addition to understanding the applicability of cultural competence in direct service settings, we must also identify the applicability and the utility of tools used in and outside of these settings. This involves reviewing documents that describe the use of outreach, provider education and other enabling services that are not necessarily provided within the confines of a direct service delivery setting.
- **Applicability to a wide range of populations:** The very nature of cultural competence requires an examination of what cultural competence signifies to a variety of different populations. While our review should include those articles that focus their attention on particular populations, we should also consider those articles that formulate approaches and models that can be applied to a wide range of populations.
- **Cultural competence and managed care:** Managed care organizations are increasingly becoming important players in the delivery of care to underserved and special populations. To ensure that managed care organizations (MCOs) are partners in the health care delivery process attempts are being made to educate MCOs on what is the necessary set of services required and how to provide those services to various populations. Articles that reflect managed care's involvement in the arena of cultural competence should be considered for review.
- **Cultural competence and quality:** Cultural competence is a key component of a quality system of care. Therefore, articles that focus on the role of cultural competence as a part of delivering high quality care should be considered for review.

- **Replicability of findings:** A key tenet of evidenced-based research is whether other researchers under similar conditions have replicated findings. Replicability provides confidence that the observed effect is a stable and reliable effect that can been consistently achieved across similar situations.
- **Generalizability of findings:** Related to the notion of replicability is whether findings possess generalizability. Generalizability is central to establishing the external validity of a study by demonstrating that findings can be generalized and applied beyond the confines of the study.
- **Explanatory power of cultural competence:** Given the multiple influences on health outcomes, it is difficult to parse out the impact of cultural competence compared to other factors in achieving desired outcomes. While there is not an expectation that cultural competence alone can explain the entirety of an observed result, articles that are able to successfully isolate the role that cultural competence plays in explaining various outcomes should be selected for review.
- **Peer-reviewed articles:** The process of peer-review ensures that an article is empirically and theoretically sound and that a high level of rigor has been applied. It is important to note that this criterion should not be applied without adequate consideration given to value of unpublished literature identified along the course of this project.
- **Empirical and consensus-based articles**: The field of cultural competence contains much research that focuses on obtaining input from critical stakeholders from different racial and ethnic groups in addition to empirically-driven research on health outcomes and health care processes. An assessment of the field would naturally extend to both empirical and consensus-based work.
- **Multiple citations of authors/studies:** In reviewing articles, it is important to identify those seminal studies and authors that have been cited in multiple publications. Multiple citations suggest that those studies and work produced by those authors have been accepted in the field as influential and as reputable bodies of work.
- **Time period:** In order to gain a historical perspective on the evolution of cultural competence as a concept, we should review articles published within a broad time period. However, in identifying the state of the art in study design and measurement, we should select those articles that have been published in the past 10 years. This will ensure that we are constructing a theoretical model built upon the seminal thinking in the field as well as developing measures and indicators that reflect the most current and cutting-edge approaches to measuring cultural competence.

Attachment 3:
Potential Measures/Indicators of Cultural Competence

ATTACHMENT 3: POTENTIAL MEASURES/INDICATORS OF CULTURAL COMPETENCE

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
VALUES AND ATTITUDES	Appreciate, respect different cultures	Checklist from the NCCC on Values and Attitudes. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never. • I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs. • I understand that traditional approaches to disciplining children are influenced by culture. • I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills.				X			Georgetown University Child Development Center-National Center for Cultural Competence (NCCC) Checklist on Values and Attitudes. Tawara Goode. June 1989. Revised 1993, 1996, 1999 and 2000

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
		• I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture. • Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations which are unique to families of specific cultures and ethnic groups served by my program or agency. • I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency. • I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.				X			

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Values and Attitudes. Appreciate, respect different cultures	Checklist from the NCCC on Values and Attitudes. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never. • I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own. • In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others. • I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency. • I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.				X			Georgetown University Child Development Center-National Center for Cultural Competence (NCCC) Checklist on Values and Attitudes. Tawara Goode. June 1989. Revised 1993, 1996, 1999 and 2000

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
		• I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents). • I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture. • I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children). • I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families). • Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.				X			

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
		• I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures. • I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.							
	Mission, vision	Mission/vision statements commit to the delivery of culturally and linguistically competent service.				X			• Maternal and Child Health Bureau (April 30, 2000). Title V Block Grant Performance Measure. Health Resources and Services Administration. • Getting Started... Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems for Children with Special Health Needs and their Families," Georgetown University Child Development Center, National Center for Cultural Competence and " "Policy Brief 1: Rationale for Cultural Competence in Health Care," Georgetown University Child Development Center, National Center for Cultural Competence
	Mission, vision	MCO self-certification that its mission statement/strategic vision support diversity and cultural competence				X			Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
CULTURAL SENSITIVITY	Non verbal communication	Translate and make available signage and commonly used written patient education and other materials for members of the predominant language groups in their service area	X						• Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda, Recommended Standards for Culturally and Linguistically Appropriate Health Care Services. • The Bureau of Primary Health Care. (1999). Cultural Competence: A Journey. Health Resources and Services Administration, Bureau of Primary Health Care. • Health Resources and Services Administration (2000). Cultural Competence Works. Awards of Excellence. "Certificates of Recognition Nominated Programs of Note" and "Certificate of Recognition."
	Non verbal communication	Number of pertinent written and oral and symbolic consumer and family materials (including consent forms, statement of rights forms, posters, signs, and audio tape recordings) provided to consumers from various racial/ethnic groups and their families that are interpreted from the appropriate cultural perspective, as measured by consumer satisfaction surveys.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Visual representation	Ensure that posters, magazines, signs are in languages of the community.	X						• The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. • The Bureau of Primary Health Care. (1999). Cultural Competence: A Journey. Health Resources and Services Administration, Bureau of Primary Health Care.
	Culturally sensitive encounters	Conduct assessment of patient/parent beliefs using the following checklist: • Identification of beliefs that affect clinical care • Suggest alternatives to harmful home remedies • Explain etiology and treatment rationale for given biomedical condition				X			Progress Notes (December 1999). A Model of Cultural Competency in Health Care. A Newsletter of the Massachusetts Chronic Disease Improvement Network. Vol.3, No.3

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Culturally sensitive clinical and non-clinical encounters	Use the following set of questions to assess folk illnesses and remedies: • Indicate awareness of the existence of a folk illness that doctor may not know about • Ask whether the patient has the illness now • Ask what treatment the patient is receiving for the condition.				X			Progress Notes (December 1999). A Model for Cultural Competency in Health Care. A Newsletter of the Massachusetts Chronic Disease Improvement Network. Vol.3, No.3
	Culturally sensitive clinical and non-clinical encounters	Conduct health beliefs inventory of patient to understand the patient's explanatory model for illness.				X			Progress Notes (December 1999). Practicing Culturally Sensitive Pediatrics. A Newsletter of the Massachusetts Chronic Disease Improvement Network. Vol.3, No.3

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
COMMUNICATION	Communication styles	Checklist from the NCCC on Communication style. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never. • For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions. • I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions. • I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency. • I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance. • When possible, I insure that all notices and communiqués to parents are written in their language of origin. • I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information				X			Georgetown University Child Development Center-National Center for Cultural Competence (NCCC) Checklist on Communication Styles. Tawara Goode. June 1989. Revised 1993, 1996, 1999 and 2000

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation

COMMUNICATION	Communication styles	Checklist from the NCCC on Communication style. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never.
		• When interacting with parents who have limited English proficiency I always keep in mind that:
		  • Limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
		  • their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
		  • they may or may not be literate in their language of origin or English.
						X			Georgetown University Child Development Center-National Center for Cultural Competence (NCCC) Checklist on Communication Styles. Tawara Goode. June 1989. Revised 1993, 1996, 1999 and 2000

	Interpreter	Yearly updated directory of trained interpreters available within 24 hours for routine situations and within one hour or less for urgent situations.		X					Center for Mental Health Services (Nov. 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/Underrepresented Racial Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Interpreter	Percent decrease in the use of interpreters as a result of increased numbers of professional staff competent in the communication styles of consumers from the ethnic/racial groups.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation

	Interpreter	Patient survey:
		• How often is an interpreter present during your office visits?(never, sometimes, frequently, always, doctor speaks my language)
		• If your primary language is other than English, which of the following services does your health plan offer in your primary language?
		  • Interpreter of bilingual staff in the emergency room
		  • Interpreter or bilingual staff in the laboratory
		  • Interpreter of bilingual staff in X-ray
		  • Interpreter or bilingual staff in EKG
		  • Interpreter for visits to authorized non-Plan providers
		• How satisfied are you with the language interpreter you receive under your health plan?
		• Have you ever had to wait more than 2 days to see a plan physician for attention to a condition which you felt required immediate attention due to the unavailability of a plan provided interpreter?
		• Who usually interprets during your office visit?
				X					Munoz, R.H., Sanchez, A.M. Developing Culturally Competent Systems of Care for State Mental Health Services. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Prepared for the Substance Abuse and Mental Health Services Administration under contract No. 94MF113927

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Interpreter	Percentage of clients with limited English proficiency (LEP) who have access to bilingual staff or interpretation services.		X					• Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services. • The Bureau of Primary Health Care. (1999). Cultural Competence: A Journey. Health Resources and Services Administration, Bureau of Primary Health Care. • Health Resources and Services Administration (2000). Cultural Competence Works. Awards of Excellence. "Certificates of Recognition Nominated Programs of Note" and "Certificate of Recognition."

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Interpreter	• Percentage of bilingual staff and interpreters certified or having formally demonstrated their linguistic competence. • Number of trainings provided to clinicians in the use of interpreters for consumers from the various racial/ethnic groups and their families. • Percentage of translators working with consumers from various racial/ethnic groups and families who are trained in formal interpretation techniques and supervised by culturally competent specialist.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Translated materials	Activities and material, including an updated listing of community resources, are provided in the language(s) of the population(s) being served.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education / promotion material	X						Maternal and Child Health Bureau. (April 30, 2000). Title V Block Grant Measure. Health Resources and Services Administration.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Translated materials	Percent of clients who receive oral and written notices, including translated signage at key points of contact, in their primary language informing them of their right to receive no-cost interpreter services.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Translated materials	Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Translated materials	• Policies and procedures regarding the translation of patient consent forms, educational materials, and other information in formats that meet the literacy needs of patients. • Policies and procedures to evaluate the quality and appropriateness of interpretation and translated services. • Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and satisfaction services that are provided.		X					National Center for Cultural Competency (Winter, 2000) Policy Brief 2: Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Translated materials	Information on rights is available in languages of community		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Linguistically competent organization	• Percent of racial/ethnic customers receiving linguistically competent services • Percentage of consumers from diverse ethnic/racial groups served in their preferred language		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Linguistically competent organization	• Language and dialects of community available at the point of first contact • # of trained translators and interpreters available • # staff proficient in languages of the community		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Linguistically competent organization	Interpreters and bilingual staff demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters				X			Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Linguistically competent organization	Linguistically and culturally factored consumer satisfaction surveys are independently administered and include health plan drop-out rates and short-term recipients.			X				Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

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	Linguistically competent organization	Patient Survey • If your primary language is other than English, which of the following services does your health plan offer in your primary language? – Health plan forms and brochures describing benefits – Answers by phone or in person to questions about plan benefits and procedures – Telephone access to doctors 24 hours a day in case of urgent need – Making appointments with your doctor – Assistance getting authorization to see a specialist – Identification of doctors who speak your language and or understand your culture – Health education and health prevention programs in your community • Handling complaints about your care or treatment by the health plan • On-going updates on plan information		X					Munoz, R.H., Sanchez, A.M. Developing Culturally Competent Systems of Care for State Mental Health Services. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Prepared for the Substance Abuse and Mental Health Services Administration under contract No. 94MF113927

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	Linguistically competent organization	Percentage of consumers from diverse ethnic/racial groups served in their preferred language.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Linguistically competent organization	Items from Patient Satisfaction Survey Tool: • How well can you communicate with your doctor in English? • How often is an interpreter present during your office visits • Who usually interprets during your office visit? • If your primary language is other than English, which of the following services does your health plan offer in your primary language? • How satisfied are you with the language interpreting you receive under your health plan? • How understandable are the written communications you receive from your health plan? • Are the instructions for using the drug prescribed for you which are on the labels of the pill bottles written in your native language? • Does the pharmacist explain the instructions for taking prescriptions to you in your native language?			X				Tirado, M. (January, 1996). Tools for Monitoring Cultural Competence in Health Care. Latino Coalition for a Health California. San Francisco, CA

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Linguistically competent organization	• Policies and procedures are in place regarding the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of the patient • Policies and procedures are in place to evaluation the quality and appropriateness of interpretation and translation services • Policies and resources are in place to support community outreach initiatives to persons with limited English proficiency. • Policies and procedures are in place to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.
	Linguistically competent organization	Comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.				X			Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

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	Linguistically competent organization	Availability of cultural competent policies in different languages.		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Linguistically competent organization	Policies and resources to support ongoing pre-service, inservice and professional development in the area of cultural and linguistic competence		X					Maternal and Child Health Bureau (April 30, 2000). Title V Block Grant Measure. Department of Health and Human Services.
	Linguistically competent organization	MCO complies with current law and regulation regarding interpreter services as measured by whether MCO meets all requirements or in a weighted average of compliance ratings for individual items		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA

Potential Measures/Indicators of Cultural Competence

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	Linguistically competent organization	Consumer education information respects cultures, reflects literacy levels and is in different formats				X			The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Linguistic capacity of provider	Conduct audit of provider network which includes the following components: • Languages and dialects of community available at points of first contact • # trained translators and interpreters available • # clinicians and staff proficient in languages of the community	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Linguistic capacity of provider	Policies to support community outreach to persons with limited English proficiency		X					National Center for Cultural Competency (Winter, 2000) Policy Brief 2: Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers.

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	Linguistic capacity of provider	Use of language fluency examinations to determine the level of competence of clinicians and interpreters to provide comprehensive clinical and preventive care		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Linguistic capacity of provider	Procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation service needs	X						National Center for Cultural Competency (Winter, 2000) Policy Brief 2: Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers.
	Language ability, oral and written of consumer	Consumer reading, writing levels of primary language and dialects recorded.		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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	Provide information, education	Resource materials are accessible to the diverse population served	X						Getting Started... Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems for Children with Special Health Needs and their Families," Georgetown University Child Development Center, National Center for Cultural Competence and " "Policy Brief 1: Rationale for Cultural Competence in Health Care," Georgetown University Child Development Center, National Center for Cultural Competence
	Provide information, education	• Information is available that: - Respects cultural values - Is in different formats • Information is available in the languages of the community. • Material is reviewed by local key informants. • Information is disseminated to provider network.	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Provide information, education	• Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Administration and staff should be able to translate, cultural brokering	Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
POLICIES AND PROCEDURES	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets which demonstrate effective service, equitable access and comparability of benefits for populations of racial/ethnic groups		X					Center for Mental Health Services (Nov. 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved Underrepresented Racial Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Choice of providers, provider network	Health plan contracts with, and utilizes local racial/ethnic community-based organizations and independent practitioners in its network and includes them in the provider's network or panel.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Choice of providers, provider network	MCO self-certification regarding specific requirements(e.g., designation as an AA/EEO employer, job descriptions include requirements for cultural competence, performance evaluations measure and reward culturally competent behaviors)		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
	Grievance and conflict resolution	Organization has structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Grievance and conflict resolution	There are feedback mechanisms in place that track # grievances and complaints and # incidents.	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Grievance and conflict resolution	Patient complaints and grievances (e.g., differences in the per capital number of complaints or grievances filed by members of each patient group)		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA
	Grievance and conflict resolution	Racial/ethnic consumer awareness of and participation in Health Plan benefits, appeals procedures, and ombudspersons, as demonstrated by the comparability of the rate of grievances and complaints.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Grievance and conflict resolution	The percentage of complaints and grievances of individual practitioners is tracked and factored into performance evaluations.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Policy development	Incorporation of cultural values and priorities in services planning/implementation/evaluation activities.		X					Nelkin, V.S. I (1994) To Improve access to Care and Quality of Life for all Children with Special Healthcare Needs and Their Families.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Policy development	Provider Survey: • As a matter of formal policy, does you agency: (no policy, considering policy, currently writing formal policy, policy in place) – Use culture-specific assessment instruments for diagnosis – Use culture-specific treatment approaches – Envision community empowerment as a treatment goal – Review case practices on a regular basis to determine relevancy to client of color – Provide or facilitate transportation – Allow access after regular business hours – Specifically consider culture in services plans – Take referrals from non-traditional sources – Translate agency materials into languages that reflect the linguistic diversity in your service area – Solicit input from groups of color with respect to physical plant location and interior design		X					Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.

Potential Measures/Indicators of Cultural Competence

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	Policy development	• Does your organization have policies, training standards, etc. That are used to promote culturally competent system of care for ethnically diverse adults with serious mental illness? Y____ N___. • What, if any, mechanism do you have for ensuring that policies are carried out?		X					Munoz, R.H., Sanchez, A.M. Developing Culturally Competent Systems of Care for State Mental Health Services. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Prepared for the Substance Abuse and Mental Health Services Administration under contract No. 94MF113927

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Policy development	Program self-assessment survey on policies and procedures: • In diagnosis and assessment, how is the client's culture taken into account? – We have rarely or never discusses this option, so far as I know – We sometimes discuss this option, and might change at some point – No special instruments or guidelines are used, but workers are instructed to take culture into account – When needed, workers or teams may use special instruments or guidelines that address cultural concerns – We have a series of assessment questions addressing culture and asked of all clients • In treating clients, how is culture taken into account? (same response options as above)				X			Weiss, C. I., & Minsky, S. (1994). Program self-assessment survey for cultural competence: A manual. New Jersey Division of Mental Health and Hospitals.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Policy Development	Program self-assessment survey on policies and procedures: • How does the program decor reflect the cultural heritage of clients and families using the facility – Music in waiting room, eating or drop-in areas, program activity spaces, etc. – Foods or beverages served or sold – Wall maps, posters, photos or other art work of places or people or objects familiar to clients (includes individuals admired by the clients' communities) – Reading matter in the waiting room or client reading area in the first language of non-English speakers or popular within clients' communities – Notices and place signs in the first language of the non-English speakers – A bulletin board with news items and other material of cultural interest, e.g., local events or media broadcasts				X			Weiss, C. I., & Minsky, S. (1994). Program self-assessment survey for cultural competence: A manual. New Jersey Division of Mental Health and Hospitals.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Policy development	Program self-assessment survey on policies and procedures: • How and when do program staff learn about: clients' cultures and their service needs and barriers to treatment; their beliefs, customs and norms, as well as diversity within the groups; and their helping resources – During orientation for new staff – During in-service training held on-site at least once a year – Through a connection with a nearby academic setting, informing the program of learning opportunities and resources – From a program plan, report or other document – By collecting information about persons who use or need the program – Through a dialogue with members of local communities – From a library of books and other resource materials on site – From a bulleting board announcing upcoming conferences; TV shows – From guest speakers – Through collaboration with outside researchers, clinicians, or others				X			Weiss, C. I., & Minsky, S. (1994). Program self-assessment survey for cultural competence: A manual. New Jersey Division of Mental Health and Hospitals.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Policy development	Program self-assessment survey on policies and procedures: • How does the program help to promote staff "of color" from within? – These staff receive career counseling, and leave from work as needed, to aim for higher positions (e.g., skill building, test taking, pursuing postings) – Promotional opportunities are announced in general staff meetings or on a circular bulleting board seen by all staff – Orientation include an affirmative action unit that tells new staff where to get more information and how to lodge a complaint – Job requirements do not bar paraprofessionals from positions where they could perform well – The program has an affirmative action bulletin board, or section of a bulletin board, that addresses discrimination in hiring or promotions – Complaints about promotions are handled promptly, fairly and without penalty to anyone complaining (even if the appeal goes outside the program) – Other				X			Weiss, C. I., & Minsky, S. (1994). Program self-assessment survey for cultural competence: A manual. New Jersey Division of Mental Health and Hospitals.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Planning and governance	Demonstration of a cultural competence system evaluation.	X						Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.
	Planning and governance	• Presence of a Cultural Competence Plan and defined steps for its integration at every level of organizational planning. • Presence, within the Cultural Competence Plan, of related policy/procedure changes.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Planning and governance	Demonstration of staff and consumer awareness and acceptance of the Cultural Competence Plan.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Planning and governance	• Presence of culturally-informed policies of practitioner behavior and performance-based demonstrations of implementation.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Planning and governance	Composition of the governing board, advisory committee, other policy-making and influencing groups, and consumers served reflects service area demographics	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Planning and governance	Health plan enrollee cultures are represented on the governing board (Data source: bios of board members)	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Potential Measures/Indicators of Cultural Competence

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	Adequate financing	Access to traditional healers is covered by the health plan's benefit package.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved /Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Staff hiring, recruitment	• # of multilingual/multicultural staff • ratio by culture of staff to clients		X					The Lewin Group (1996) Draft Performance Indicator Worksheet. Title IV. Prepared for HRSA.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Staff hiring, recruitment	Provider survey: • Are there people of color on the staff of your agency? • Are there people of color represented in: (none, a few, some, many) – Administrative positions – Direct service positions – Administrative support positions – Operational support positions – Board positions – Agency consultants – Case consultants – Sub-contractors • Does your agency: (none, a few, some, many) – Hire natural helpers or other non-credentialed people of color as paraprofessionals – Hire practicuum students or interns of color – Out-station staff in communities of color – Hire bilingual staff • Does your agency emphasize active recruitment of people of color? • How well has your agency been able to retain people of color on staff?		X					Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.

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	Staff hiring, recruitment	Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Staff hiring, recruitment	Presence of a plan for recruitment, retention and promotion of staff of racial/ethnic backgrounds representative of the target population served.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Staff hiring, recruitment	Recruitment, retention, and career development plan for racial/ethnic and other culturally competent mental health professionals.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Staff hiring, recruitment	Proportionality of racial/ethnic staffing to the needs of diverse racial/ethnic populations.		X					Center or Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Staff hiring, recruitment	Human Resource Development Plan is inclusive of recruitment, retention and development of staff at all levels to enhance and ensure quality culturally competent services to consumers from the four groups and their communities.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Incentive systems	Development of rewards and incentives (e.g., salary, promotion, bonuses) for cultural competence performance as well as sanctions for cultural destructive practices.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Incentive systems	Cultural competence is an integral part of the employee-provider performance evaluation system, and provider organization performance system.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Incentive systems	Demonstration of staff knowledge and skills regarding group values, traditions, expression of illness, cultural competence principles (e.g., credentialing and performance based testing).				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Incentive systems	Job responsibilities and performance measures for staff and contracted providers include criteria (knowledge, skills, etc.) related to cultural and linguistic competence and cross-cultural communication.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

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TRAINING AND STAFF DEVELOPMENT	Training and professional development	Cultural competence training is part of the credentialing process for case managers.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Training and professional development	Budgetary expenditures each year are allocated to professional development related to cultural competence.	X						Getting Started... Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems for Children with Special Health Needs and their Families," Georgetown University Child Development Center, National Center for Cultural Competence and " "Policy Brief 1: Rationale for Cultural Competence in Health Care," Georgetown University Child Development Center, National Center for Cultural Competence

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	Training and professional development	The following four elements demonstrate cultural competent training. Respondents were asked to check the degree to which the elements have been incorporated using a scale of 0 (not met) to 3 (completely met): • A written cultural competence plan for your training program emphasizes your commitment to delivering a culturally competent training experience to your staff; • Cultural and linguistic competency policies are incorporated into the overall administration of your program (recruitment plan and other policies and procedures); • Cultural and linguistic competence knowledge and skills building are included in the didactic portion of your training experience; and • Cultural and linguistic competence knowledge and skill building are included in the practicum/field/clinical experience portion of your training experience		X					Maternal and Child Health Bureau (2000) MCHB Performance Measures Detail Sheet Number 21. Developed by The Lewin Group.

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	Training and professional development	Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Training and professional development	• % administrative staff with cultural competence training • % of administrative staff attending ongoing cultural competence training • Ongoing cultural competence training completed		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Training and professional development	• Development of specific job descriptions of staff who work with patients of diverse cultural groups. • Percentage/number of staff receiving initial and ongoing cultural competence training.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

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	Training and professional development	The following are indicators of culturally competent human resource planning by a health plan: • Percentage of consumers from diverse ethnic/racial groups served by, or under the supervision of, culturally competent bilingual/bicultural Mental Health Specialists. • Percentage of staff receiving at least five hours of training annually in cultural competence awareness.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Training and professional development	• MCO self-certifies that it provides cultural competence training for selected staff • MCO demonstrates effectiveness of cultural competence training by measuring pre/post knowledge of participants • MCO demonstrates effectiveness of cultural competence training by measuring its impact on clinician/patient interactions and satisfaction and/or clinical outcomes		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA

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	Training and professional development	Provider Survey: • Does your agency prepare new staff to work with people of color? (not at all, barely, fairly well, very well) • Does your agency provide training that helps staff work with people of color? (not at all, barely, fairly well, very well)		X					Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.
	New staff orientations	# of new employee obtaining at least eight hours of cultural training per year		X					Texas Department of Health. Journey Towards Cultural Competency: Lessons Learned. National Maternal and Child Health Resource Center on Cultural Competency. Prepared for the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.
	Structured opportunities for ongoing learning								
	Bilingual training	Percent of interpreters and bilingual staff that demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

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	Assessment of the knowledge and skills/ attitudes of the provider.	Items from the Provider Self-Assessment Survey • Some specific diseases are more common in 1 particular ethnic or racial group compared to another. Assign the following conditions to the groups in which they are more common • Which of the following types of patients do you find most challenging to care for? (english speaking patients with symptomatic acute conditions, non-english speaking patients with symptomatic acute conditions, english speaking patients with symptomatic chronic conditions) • How do you test the quality of the interpretation when using an interpreter with a non-english speaking patient? • On the average, how frequently do you meet with people who interpret for you to discuss communications with your patients? • Where available, family members, such as a patient's children, should be utilized to ensure more candid responses to the provider's questions?				X			Tirado, M. (January, 1996). Tools for Monitoring Cultural Competence in Health Care. Latino Coalition for a Health California. San Francisco, CA

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	Assessment of the knowledge and skills/ attitudes of the provider.	Items from the Provider Self-Assessment Survey • Where a provider's knowledge of the patient's language is limited, he or she should avoid trying to converse with the non-English speaking patient? Y or N • How common is it for non-English speaking patients ethnically diverse patients to mix traditional treatments with the Western interventions physicians have prescribed for them? • Do you feel that those of your patients who mix traditional treatments with Western medications should be free to continue to use traditional remedies as long as those traditional remedies are not harmful? • If your patient is found to be using such non-harmful traditional treatments, how would you as the attending physician react?				X			Tirado, M. (January, 1996). Tools for Monitoring Cultural Competence in Health Care. Latino Coalition for a Health California. San Francisco, CA

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	Assessment of the knowledge and skills/ attitudes of the provider	Items from the Provider-Self Assessment Tool: • A provider should anticipate similar medication reactions when ordering prescriptions for one's non-English speaking ethnically diverse patients as compared with one's English speaking patients assuming that all other things are equal? (strongly agree, agree, no opinion, disagree, strongly disagree) • When prescribing medications for limited English speaking patients from a culturally diverse ethnic/racial group, it is oftern advantageous to prescribe smaller quantities of the medication per prescription in order to allow more frequent monitoring of their compliance with the treatment? (strongly agree, agree, no opinion, disagree, strongly disagree)				X			Tirado, M. (January, 1996). Tools for Monitoring Cultural Competence in Health Care. Latino Coalition for a Health California. San Francisco, CA

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	Assessment of the knowledge and skills/ attitudes of the provider.	Periodic review is conducted of the cultural competence of the provider network		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Assessment of the knowledge and skills/ attitudes of the provider.	Existence of provider network review procedures in the cultural competent plan		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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	Assessment of the knowledge and skills/ attitudes of the provider.	Establishment and evaluation of a credentialing process for racial/ethnic Mental Health Specialists.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Assessment of the knowledge and skills/ attitudes of the provider.	Checklist to assess cultural competence of provider: • Demonstrate attitudes that indicate a respect for the consumer's immigration, migration, colonization, and acculturation experiences. • Demonstrate attitudes that indicate a respect for the diverse heritages, cultures, and experiences of consumers from the four groups. • Demonstrate attitudes that indicate a willingness to work with culturally, ethnically, and racially diverse populations.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Assessment of the knowledge and skills/ attitudes of the provider.	• Employee evaluation examines completed cultural competence training • Employee evaluation examines attended ongoing cultural competence training • Employee evaluation examines violated cultural competence principles		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Cultural knowledge	Demonstration of staff knowledge and skills regarding group values, traditions, expression of illness, cultural competence principles.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Knowledge of community needs	Provider shall demonstrate ongoing assessment of health and behavioral needs of racial/ethnic groups and their communities.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Provider preparation	Percentage/number of staff receiving initial and ongoing cultural competence training.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
FACILITY CHARACTERISTICS, CAPACITY, AND INFRASTRUCTURE	Available and accessible services	• Transportation available from residential areas to cultural competent provider • Flexibility to conduct home visits and community outreach • Culturally competent services available evenings and weekends	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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	Available and accessible services	• Proportionality of access to, and length of service of, the full range of treatment services offered should be comparable to overall service recipients for access to specific levels and types of services. • Percent of consumers from ethnic/racial groups receiving blended, coordinated or wrap-around services is comparable to overall service population. • Rate and timeliness of response to telephone calls by consumers from racial/ethnic groups.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

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	Physical environment, materials, and resources	Checklist from the NCCC on Physical Environment. Indicate A= things I do frequently B= things I do occasionally C= Things I do rarely or never. • I display pictures, posters and other materials which reflect the cultures and ethnic backgrounds of children and families served by my program or agency. • I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency. • When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency. • When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency. • I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.	X						Georgetown University Child Development Center-National Center for Cultural Competence (NCCC) Checklist on Physical Environment. Tawara Goode. June 1989. Revised 1993, 1996, 1999 and 2000

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	Physical environment, materials, and resources	Develop institutional structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair culturally insensitive or discriminatory treatment, or difficulty in accessing or denial of services.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Information system	Maintenance of timely and accurate consumer data which provides for tracking across age and race ethnicity.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Information system	Tracking of access and utilization rates for populations of the different racial/ethnic groups in comparison to the overall service population.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.

Potential Measures/Indicators of Cultural Competence

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	Information system	• Clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff. • Having a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in service area and become informed about the ethnic/cultural needs, resources and assets of the surrounding community • Timely and accurate consumer data which provides for tracking across age and race/ethnicity.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Information system	Inclusion of cultural competence elements in management information systems.	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
INTERVENTIONS AND TREATMENT MODEL FEATURES	Diagnosis, care planning, referral and treatment	Psychosocial evaluation conducted by qualified practitioners trained in ethnic-specific biological, physiological, cultural, socioeconomic and psychological variables				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Diagnosis care planning, referral and treatment	Provider Survey: • Do you use treatment interventions that have been developed for populations of color? (not at all, seldom, sometimes, often) • Do your treatment plans contain a cultural perspective that acknowledges different value systems of people of color? (not at all, seldom, sometimes, often) • Do you use ethnographic interviewing as a technique to gather more accurate information? (not at all, seldom, sometimes, often) • Are you familiar with the limitations of mainstream diagnostic tools as applied to people of color? (not at all, seldom, sometimes, often)		X					Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Diagnosis, care planning, referral and treatment	Client assessment are conducted in client's primary language		X					Cultural Competence Works. January 10, 2000 Awards Ceremony. Description of SouthCove Community Health Center
	Diagnosis, care planning, referral and treatment	The ratio of the black infant mortality rate to the white infant mortality rate			X				Maternal and Child Health Bureau (April 30, 2000). Title V Outcome Measure
	Diagnosis, care planning, referral and treatment	Deaths of infants and children aged 0 through 24 years enumerated by age, subgroup, race and ethnicity.			X				Maternal and Child Health Bureau (April 30, 2000). Title V Developmental Health Status Indicator
	Diagnosis, care planning, referral and treatment	Psychological evaluation is provided that is based on the use of culturally and linguistically competent literature and other specialized approaches.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/Underrepresented Racial Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Diagnosis, care planning, referral and treatment	Decrease in misdiagnosis and inadequate treatment plans resulting from failure to communicate effectively with consumers from various racial and ethnic groups.			X				Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

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	Diagnosis, care planning, referral and treatment	Percent of enrollees who report they were unable to obtain referral to a clinician of preferred background (either from survey of enrollees or from administrative records) overall or by demographic group.		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
	Diagnosis, care planning, referral and treatment	• Compliance with regimens, follow-up visits (e.g. differences in percentage of patients with apparent con-compliance based on chart reviews or missed out-patient appointments • Disease staging (i.e., statistically significant and material differences among groups of enrollees in state at first treatment/diagnosis) • Pharmaceutical records (e.g., the rates of reported errors by providers in prescribing medication to different patient groups)		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Culturally competent services	# of services types adapted to different cultures.		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Culturally competent service	Indicators of a culturally competent treatment service provided to minority members in health plan: • Consumer and family satisfaction with treatment services. • Inclusion of culturally specific activities and domains of daily living (e.g., housing, access to primary health care and maintenance, family role, behavioral/developmental, vocational/ educational/employment, and community tenure) in treatment services. Benchmark: Comparable to overall population served and significant improvement in at least one domain of function for more than 75% of consumers. • Rates of symptom relapse and recidivism into restrictive level of care or other restrictive placements. Benchmark: Comparable to overall population served and significant reductions over time. • Rates of medication side effects, adverse incidents, and utilization of latest pharmacological interventions. Benchmark: Comparable to overall population served and reduction of medication side effects and adverse incidents. • Rates of adverse occurrences during treatment (e.g., suicide, homicide, self-injury, accidents, physical and sexual abuse) within comparable age groups.			X				Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

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	Culturally competent service	Demonstrated incorporation of value of cultural identity, including ethnicity (subgroup membership and mixed origin) and other relevant factors in treatment services.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Culturally competent services	Culturally competent service provision by managed care organizations whose "covered lives" include minorities: • Effectiveness of an outreach program for Puerto Rican adolescents with asthma in conjunction with population-based measures of restricted activity caused by asthma; • Mammography rates among minority women; • Member satisfaction with language and cultural translation (or brokering) services			X				Risa Lavizzo-Mourey, MD, MBA Elizabeth R. Mackenzie, PhD (1996) Cultural Competence: Essential Measurements of Quality for Managed Care Organizations. Annals of Internal Medicine, 124:919-921.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Culturally competence and quality of care	Indicators of quality of care provided by health plan: • Proportional representation of consumers from various racial/ethnic groups, providers, and community members on the quality improvement team. • Occurrence of quality studies focusing on the use of best practice in resolution of deficiencies in the care of consumers from racial/ethnic groups. • Linguistically and culturally factored consumer satisfaction surveys which are independently administered and include Health Plan drop-outs and short term recipients. • Regular reporting of racial/ethnic specific quality assurance data to the governing entity, including appeals and grievances. • Rates of drop-out, grievances, restrictive care, unusual occurrences, and adverse events for consumers from racial/ethnic groups.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Culturally competent health benefit design	Indicators of culturally competent benefit design by health plan: • Culturally competent eligibility and level of care criteria are formally established. • Eligibility determinations and service planning are performed by, or under the supervision of linguistically and culturally competent bilingual/bicultural specialists. • Consumers from the various racial/ethnic groups receive direct services provided by or from culturally competent bilingual/bicultural personnel, or by personnel supervised by culturally competent bilingual/bicultural racial/ethnic mental health specialists. • Consumers receive consumer-friendly bilingual materials on Health Plan benefits. • Percent of covered consumers who know benefits and how to access them.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

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	Culturally competent treatment plan	The organization has a written policy and a demonstrated practice linking families to advocacy and education groups.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Culturally competent treatment plan	There is evidence in the Treatment Plan that proposed psychotherapeutic modalities address specific cultural issues and are conducted with specific cultural values.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Culturally competent care	Culturally Competent care: • Conducts home visits for special outreach • Sponsors a community health fair • Works with local organizations and community leaders		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Input into treatment decision and service quality	Use of culturally appropriate community resources (e.g., family, clans, etc) in the development of treatment plans.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Input into treatment decision and service quality	Use of culturally informed individuals, including family members when appropriate, by clinicians serving consumers from various racial/ethnic groups.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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	Input into treatment decision and service quality	• The Treatment Plan reflects both consumer and family involvement in its development and agreement. The degree of family involvement depends on the wishes of the consumer. • The Treatment Plan was developed with a culturally competent clinician or consultation from such a clinician • Consumer and family involvement and investment in the development of, and agreement with, the Care Plan. • Culturally defined needs addressed in the care plans of consumers from various racial/ethnic groups. • Leadership by racial/ethnic Mental Health Specialists in the care planning process for consumers from various racial/ethnic groups.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Input into treatment decision and service quality	• Involves culturally diverse groups in the planning process • Conducts focus groups concerning the needs of cultural groups		X					Maternal and Child Health Bureau (1990-1991). Improving State Services for Culturally Diverse Populations: MCHB's Division of Services for Children with Special Health Needs Activities

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Use of medicines according to cultural belief and ethnopharma-cology								
	Use of traditional healers and healing methods	• Integration of "natural supports" (i.e., family members, religious and spiritual resources, traditional healers, churches, etc.) in the treatment care plan. • Inclusion of traditional healers in the Care Plan for consumers or family from the various racial/ethnic groups, except when contraindicated.		X					Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Use of traditional healers and healing methods	Provider utilizes indigenous healing practices and the role of belief systems (religion and spirituality) in the treatment of consumers from underserved/ underrepresented groups.				X			Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Use of traditional healers and healing methods	• # natural helpers, alternative community resources included in health plan resource directory • # of referrals to culturally competent services by health plan		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Use of traditional healers and healing methods	Percent of consumers receiving services by traditional healers.		X					• Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services. • The Bureau of Primary Health Care. (1999). Cultural Competence: A Journey. Health Resources and Services Administration, Bureau of Primary Health Care.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Use of traditional healers and healing methods	MCO provides and documents awareness training in "non-traditional, alternative, and complementary health practices which providers may encounter in their clinical practice, and to consider these in the context of cultural beliefs and values.		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
	Use of interdisciplinary teams	Coordination of services and case management a the community level that is appropriate for diverse populations.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.
	Use of inter-disciplinary teams	MCO self-certifies that it has developed and implemented policies and procedures to support cross-disciplinary practice among "traditional" clinicians (e.g., doctors, nurses, therapists, etc.) and with caregivers from other backgrounds (e.g., acupuncturists, chiropractors, traditional healers, etc.) MCO provides and documents clinician training on interdisciplinary collaboration, includes training specific to caregivers commonly serving MCO enrollees.		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
FAMILY AND COMMUNITY PARTICIPATION	Family centered care	Method to assure representation of different perspectives in a community-based strategic planning process such as the inclusion of: consumers and consumer groups ethnic, racial, and/or cultural minority groups pediatric / adolescent health care providers non-profit agencies insurance/business representatives legislators religious groups school district officials	X						Johns Hopkins University (1995) Child Health Systems Primary Care Assessment: Community Self-Assessment Guide. Child Adolescent Policy Center at JHU. Prepared for MCHB
	Family centered care	Community and family members of diverse cultures are involved in all partnerships and collaborations of the system.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Family centered care	Patient Survey: • Do members of your family or friends play a role in your making health decisions? • Does your doctor ask you about family members' or friends' roles in your health-related decisions and actions? • If you have told you doctor that your family or friends play a role in your health related decisions and actions, how often does he or she make an effort to communicate with that person or persons? • When you are discussing serious conditions or therapies, how often does your doctor have other adult family members in the room with you taking part in your discussions?		X					Munoz, R.H., Sanchez, A.M. Developing Culturally Competent Systems of Care for State Mental Health Services. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Prepared for the Substance Abuse and Mental Health Services Administration under contract No. 94MF113927

Potential Measures/Indicators of Cultural Competence

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	Community and consumer participation	Program self-assessment survey on policies and procedures: • Which of the groups below, reflecting clients' cultures, does the program contact from time to time? (These contacts could serve some or all of the following purposes: referral exchanges, staff or board recruitment and training, public information or education, client or community advocacy, etc. – Folk healers or practitioners – Clergy and their congregations – Media (radio, TV, newspapers, magazines) and media staff or personalities – Civil/human rights organizations, advocacy groups, tribal or cultural organizations or other groups which work for systems change – Business leaders – Service providers – Special programs for minority education or minority studies – Other				X			Weiss, C. I., & Minsky, S. (1994). Program self-assessment survey for cultural competence: A manual. New Jersey Division of Mental Health and Hospitals.

Potential Measures/Indicators of Cultural Competence

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	Community and consumer participation	Extent of family/consumer representation on coordinating council for families, professionals, educators	X						Maternal and Child Health Bureau (1995) Systems Indicator: Development of Community Performance Measures. A Preliminary Strategy for Assessing Community Systems of Care for Women, Children and Adolescents.
	Community and consumer participation	Extent of family participation in community needs assessment, planning, implementation and evaluation of a system of care		X					Maternal and Child Health Bureau (1995) Systems Indicator: Development of Community Performance Measures. A Preliminary Strategy for Assessing Community Systems of Care for Women, Children and Adolescents.
	Community and consumer participation	Extent to which systems utilize family members as providers of care coordination and peer counseling.		X					Maternal and Child Health Bureau (1995) Systems Indicator: Development of Community Performance Measures. A Preliminary Strategy for Assessing Community Systems of Care for Women, Children and Adolescents.
	Community and consumer participation	Degree to which families participate in key decision-making activities. (Checklist) • Family participation on advisory committees or task forces; • Hiring of family members to serve as consultants to providers/programs; and • Inclusion of family members in planning, implementation and evaluation of program activities.		X					Maternal and Child Health Bureau (2000) Draft performance measures. Prepared by The Lewin Group.

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	Community and consumer participation	Utilize family members as speakers		X					Johns Hopkins University (1995) Child Health Systems Primary Care Assessment: Community Self-Assessment Guide. Child and Adolescent Policy Center at Johns Hopkins University. Prepared for the Maternal and Child Health Bureau.
	Community and consumer participation	• # of meetings with family, AMI groups, advocate participation (Data source: attendance records) • Family, advocate, participants represent cultures of the community (Data source: attendance records • Family satisfaction with meetings (Data source: participant evaluation form)		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Community and consumer participation	• # of meeting with consumer participation (Data source: attendance records) • Consumers participants represent cultures of the community (Data source: attendance records) • Consumer satisfaction with meetings (Data source: participant evaluation form)		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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	Community and consumer participation	# of meetings with community leaders, key informant (i.e., politicians, law enforcement, business, clergy) participation		X					The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Community and consumer participation	Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Community and consumer participation	• Including extended family members in family/provider meetings and conferences • Participation by culturally diverse families in local and State policy and planning groups, and on project advisory boards.		X					Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

Potential Measures/Indicators of Cultural Competence

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	Family focus, family-oriented, recognition of the uniqueness of the role of the family	Degree to which: • Include parents on advisory group • Developed parent advisory committees • Hired parents as staff		X					Nelkin, V.S. (1994) Implementing the Surgeon General's Action Agenda. Survey of SPRANS Grantees. Prepared for the Maternal and Child Health Bureau.
	Family focus, family-oriented, recognition of the uniqueness of the role of the family	Degree to which: • Conducted focus group with families • Include parents as partners in policymaking • Include parents as partners in planing and implementation		X					Nelkin, V.S. (1994) Implementing the Surgeon General's Action Agenda. Survey of SPRANS Grantees. Prepared for the Maternal and Child Health Bureau.
	Family focus, family-oriented, recognition of the uniqueness of the role of the family	Family participation in development of training curriculum • Provide input through family advisory group • Incorporate review by families of training materials • Parents consult and assist in developing materials		X					Nelkin, V.S. (1994) Implementing the Surgeon General's Action Agenda. Survey of SPRANS Grantees. Prepared for the Maternal and Child Health Bureau.
	Coalition-building	Developed a family resource network	X						Nelkin, V.S. (1994) Implementing the Surgeon General's Action Agenda. Survey of SPRANS Grantees. Prepared for the Maternal and Child Health Bureau.

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	Coalition-building	Developed a parent-to-parent network which includes the following elements: • Provide financial support to families to facilitate parent-to-parent program • Disseminate information through parent resource centers • Provide mentors for "new" parents entering the system • Developed a parent support telephone network	X						Nelkin, V.S. (1994) Implementing the Surgeon General's Action Agenda. Survey of SPRANS Grantees. Prepared for the Maternal and Child Health Bureau.
	Coalition-building	• Education and training linkages are made with faith-based organizations in the community. • The organization coordinates education and outreach activities with community cultural organizations.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Coalition-building	Developing interstate coalitions to promote continuity in care, and to deal with eligibility, identification and tracking and case management issues.	X						Maternal and Child Health Bureau (1990) State Children with Special Health Care Needs Title V Directory Workshop: Improving State Services for Culturally Diverse Populations.

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	Community outreach	• MCO publicly reports on community involvement (e.g., community benefits reporting model) • External reviewer evaluates level of community involvement	X						Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
MONITORING, EVALUTION AND RESEARCH	Consumer/ Member satisfaction and feedback	Satisfaction rates due to communication styles and linguistically competent services to racial/ethnic consumers.			X				Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Consumer/ Member satisfaction and feedback	• MCO assesses patient satisfaction and clinician satisfaction with access to alternative health practices • MCO assesses patient and clinician satisfaction with access to team-based care including participation of caregivers from diverse communities.				X			Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Consumer/ Member satisfaction and feedback	% of consumers satisfied cultural competence of MCO as measures by: • Did the MCO allow you to communicate in your preferred language? • Was the MCO respectful of your health beliefs and practices? • Do you have a preference regarding the demographic characteristics of your clinician? • Were you able to choose a clinician that had these characteristics?			X				Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
	Community needs assessment	Organization has the capacity to conduct community profiles containing information on the percentage of the following that characterize target population: • % cultures • % age and % gender • % religions • % refugees and immigrants • % income distribution • % unemployed • % languages spoken and read • % non-English speaking • % 4th grade reading levels • types alternative/ complementary services	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

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Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Community needs assessment	Organization has the capacity to conduct enrollee profile contains the following information: • % cultures • % age and % gender • % religions • % refugees and immigrants • % income distribution • % unemployed • % languages spoken and read • % non-English speaking • % 4th grade reading levels • types alternative/ complementary services • prior service use	X						The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Community needs assessment	• The Managed Care Mental Health Plan assesses the existence of racial/ethnic groups in the population being served, assesses the needs and risk factors associated with those populations, and takes these factors into consideration in prevention, education, and outreach activities. • The Managed Care Mental Health Plan maintains a list of cultural community organizations and documents the utilization of these organizations to assist in education and outreach	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Community needs assessment	• MCO self-certifies that is obtains community input regarding needs • MCO self-certifies that is obtains community input via specific mechanisms (e.g., surveys, focus groups, public meetings, advisory committees) • Self-certifies that specific information is provided (e.g., demographics on race/ethnicity/gender/age lang uage/religion/sexual orientation) • Collects information on patients' racial and ethnic self-identification and primary language. • Analyzes utilization of services and outcomes to identify disparities among groups and uses this information to improve performance.	X						Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Community needs assessment	Provider Survey on Knowledge of Communities: • How well are you able to describe the communities of color in your service area? (not at all, barely, fairly well, very well) • List the cultural groups of color who reside in your service area and how much of the overall population this represents. • How well are you able to describe within-group differences? (not at all, barely, fairly well, very well) • How well are you able to describe the strengths of the groups of color in your service area? (not at all, barely, fairly well, very well) • How well are you able to describe the social problems of the groups of color in your service area? (not at all, barely, fairly well, very well) • Do you know the prevailing beliefs, customs, norms and values of the groups of color in your service area? (not at all, barely, fairly well, very well) • Do you know the greeting protocol within communities of color? (not at all, barely, fairly well, very well)	X						Mason (1995) Cultural Competence Self Assessment Questionnaire: A Manual for Users. Multicultural Initiative Project, Portland Sate University, Research and Training Center on Family Support and Children's Mental Health.

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Organizational Assessment	• Percent of staff saying MCO is not competent to care for some group. • Average percent of enrollees in groups for whom staff members say MCO does not provide competent care.		X					Abt Associates (January, 2000). Report on Recommendations for Measures of Cultural Competence for the Quality Improvement System for Managed Care. Report prepared for HCFA.
	Organizational Assessment	• Conduct of ongoing organizational self-assessments of cultural and linguistic competence, and integration measures of access, satisfaction, quality, and outcomes into other organizational internal audits and performance improvement programs. • Prepare an annual progress report documenting the organization's progress with implementing CLAS standards, including information on programs, staffing, and resources.	X						Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.
	Evaluation of health plans	Time from point of first contact through service provision for all levels of care are tracked by age, gender, ethnicity (i.e., particular subgroup and mixed origins), primary language, and level of functioning.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D

Potential Measures/Indicators of Cultural Competence

Domains/Definitions	Topic Area	Measures/Indicators	Capacity/ Structure	Process	Outcome/ Impact	Org. Viewpoint	Vantage Point	Usage	Literature Citation
	Evaluation of health plans	Tracking of health plans' authorizations decisions including denials, rationale, and disposition by ethnicity.	X						Center for Mental Health Services (Nov, 1998)) Cultural Competence in Managed Care. Overall System Standards and Implementation Guidelines. Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups Prepared for Substance Abuse and Mental Health Services Administration. Purchase Order No. 97MO4762401D
	Evaluation of services	Measure of program retention and drop out rates through: rates of service use, reason-specific no-show rates, reason-specific drop-out rates			X				The New York State Office of Mental Health. The Research Foundation for Mental Hygiene. (September 1998) Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. In Collaboration with the Center for the Study of Issues in Public Mental Health. Funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
	Evaluation of provider	Percentage of complaints and grievances of individual practitioners is tracked and factored into performance evaluations.		X					Office of Minority Health (1999) Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda Recommended Standards for Culturally and Linguistically Appropriate Health Care Services.